



# **EVALUATION REPORT ON FAMILY PLANNING PROGRAMME**



**PROGRAMME EVALUATION ORGANISATION  
PLANNING COMMISSION  
GOVERNMENT OF INDIA  
NEW DELHI**

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ON  
FAMILY PLANNING PROGRAMME



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## P R E F A C E

Although the Family Planning Programme has been in operation in the country for over three decades now it has a vital and continuing importance both from the standpoint of the need to control and stabilise the Growth of population and of enhancing the welfare impact of further economic development. It has been adopted as a national programme by the Government of India. The promotion of family planning on a voluntary basis as a people's movement was also one of the points included in the New 20-Point Programme announced by the late Prime Minister Shrimati Indira Gandhi on 14th January, 1982. In view of the importance of this programme the Planning Commission suggested to its Programme Evaluation Organisation (PEO) to undertake another evaluation study on the working of this programme. The present evaluation study was accordingly planned and launched in the field in January, 1983 with the following as its main objectives :

- (i) to study the organisational set up for the implementation of the programme, particularly for educating and motivating the people;
- (ii) to examine the communication strategy adopted in terms of creating awareness, change in attitude and adoption of family planning methods, and popularising the concept of "small family norm" ;
- (iii) to assess the extent of service facilities and supplies made available and their utilisation;
- (iv) to understand the constraints experienced and problems faced in the implementation of the programme;
- (v) to assess the role played by voluntary organisations in promoting the programme as a people's movement ; and
- (vi) to assess the views and reactions of the adopters and non-adopters towards the family planning programme.

2. The study was confined only to rural areas. It was undertaken in 31 selected districts in 16 States and covered 62 primary health centres (PHCs) and 124 villages. In each State two districts—one progressive and the other non-progressive were selected on the basis of the highest and lowest number of adopters per thousand of population. A total of 1630 village level respondents were canvassed of which 1024 were adopters, i.e. those practising family planning, and the remaining 606 were non-adopters. The details of the sampling procedure adopted for the study are set forth in Chapter I of the Report. The field work for the study was undertaken during the first quarter of 1983. During the field survey both quantitative and qualitative data were collected with the help of structured schedules and guide-points issued to the field staff. Information was gathered for the years 1980-81, 1981-82 and 1982-83 (upto December, 1982) at the State, District, PHC and village levels.

3. Based on the data and information collected the report comes out with a number of findings and makes several recommendations for improving the operational efficacy of the programme. A summary of the main findings and recommendations is given in Chapter 8 of the report together with a broad indication of the agency/agencies concerned with follow-up action in respect of the relevant recommendations. A short account of some of the main findings and recommendations is, however, presented in the succeeding paragraphs.

4. The information collected for the study revealed that the non-adopters were almost as knowledgeable and convinced about the advantages of family planning as the adopters. Thus, in the matter of the generation of awareness for the need for family planning the programme had done its part and created the necessary consciousness both among the adopters as well as non-adopters. The non-adoption of family planning, the study brings out, was not for want of knowledge about family planning methods on the part of non-adopters but because of other reasons. As regards the level of knowledge of different family planning methods among the sample adopters and non-adopters, a large proportion of both adopters and non-adopters were aware of the terminal methods of tubectomy and vasectomy. The non-terminal methods of IUD/Copper-T and condom were known to a much lower percentage of the respondents. This state of knowledge of different family planning methods could, in a sense, be taken to reflect the relative degree of emphasis on these methods in the operation of the programme. It is surprising that the medical termination of pregnancy (MTP) was known to only 0.4 per cent of sample adopters and 0.2 per cent of sample non-adopters.

5. The heavy and practically exclusive emphasis on the terminal methods of tubectomy and vasectomy also throw some light on the pertinent enough aspect of their being non-adopters despite the family planning programme having been in operation for over three decades. Conceivably, if a large enough percentage of eligible couples did not want to terminate their option to have children later on, and were not well informed regarding the option of non-terminal methods available to them, especially the MTP method, this could have

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been a major reason for their remaining non-adopters. If it is made known to the eligible couples that there are methods of family planning which make the option of revocability available to them, this will go a long way in their overcoming the hesitations and fears in respect of the adoptions of family planning. It should, therefore, be the endeavour of the agencies/functionaries concerned with the family planning programme, the report recommends, to inform the eligible couples on all types of methods of family planning, clearly differentiating between the 'terminal' and 'non-terminal' options available instead of placing all out emphasis, in terms of persuasion and incentives, on terminal methods simply because these happen to be certain and irrevocable. Further, a main plank of the efforts to spread the knowledge about family planning should be clearly explain to all eligible couples that if and when a particular non-terminal method may fail and/or an unwanted pregnancy takes place the foolproof MTP method would still be available. The knowledge regarding the availability of MTP method should help induce a significant proportion of non-adopters to adopt at least non-terminal methods.

6. Among the sample households canvassed, it was found that in the case of scheduled castes, scheduled tribes and backward classes the percentage of adopters using terminal methods was considerably higher than that of those practising non-terminal methods. It was also found that in the occupational category of labourers the percentage of sample adopters using terminal methods was appreciably higher than those using non-terminal methods. The extension efforts to cover more and more people under family planning could take note of the comparative preference for terminal methods among these groups and categories so as to cater more adequately to their preferred methods.

7. Those who had gone in for family planning had done so chiefly for economic or personal reasons and on health and medical grounds. Of the 1024 adopters canvassed, 49.6 per cent had adopted family planning for mainly economic reasons ; 17.4 per cent on health and medical grounds ; 0.4 per cent because they found the recommended methods easy to adopt and reversible, if desired; and the remaining 29.1 per cent for other general reasons. Among general reasons given "small family happy family" came out as having the widest appeal. This suggests that it is a distinct stress on these advantages of family planning which would evoke maximum response to the message of family planning programme.

8. The incentives provided under the programme were, by and large, an inconsequential factor in decision for the actual adoption of family planning. From among the adopters who had received incentives only about one-third said that they were satisfied with the incentives offered to them ; another one-third said that they were not ; and the rest expressed no view. As to the suggestions of the sample adopters who made suggestions in respect of the incentives given, 89 per cent said that the incentive amount should be more. A little over 42 per cent of the suggestions were for giving preferential medical treatment, 21.7 per cent for giving full compensation for loss of wages and 12.9 per cent for provision of free transport and free accommodation at a PHC/hospital.

9. In as much as the rationale behind the provision of compensation/incentive is only removing the hinderance of transitory factors like loss of wages, costs involved in travel, enforced absence from work, etc., which could come in the way of the adoption of a suitable family planning method, the quantum of compensation incentive given should be more closely related to these aspects. On the other hand, if the purpose is also to provide an inducement for going in for family planning, the incentive should be reasonably attractive. Further, the quantum of compensation/incentive for those going in for vasectomy, tubectomy and IUD insertions should not be the same for all categories of adopters of these devices and should instead be related in a suitable manner to the stage at which these methods are adopted. The amount of the incentive should be considerably higher if these methods are adopted after the birth of the first child, less after the second child and the lowest after the third child. The case for evolving such a graded system of incentives rests on the ground that it is the early adoption of an effective family planning method which deserves to be compensated for rather than its adoption at a late stage when a couple has already got two or three children. That is to say, the distinct emphasis of any system of incentives should be on restricting the number of children and population growth and not merely on the adoption of a terminal method at any stage.

10. The follow-up facilities should be suitably strengthened so that these are adequate and also regularly available. A *modus operandi* should be evolved whereby prompt treatment is given in cases of complaint and thereafter regular follow up is done. To this end all cases of vasectomy, tubectomy and of IUD should be regularly reviewed at stipulated intervals on a continuous basis. There is also need for increasing the frequency of contact of the family planning staff with the villagers. While to an extent more frequent contact and domiciliary visits may be possible by careful harnessing of the available resources and exercising proper checks and inspection to ensure that the stipulated number of visits to villages, etc., are in fact made by the concerned staff, where necessary the number of villages per PHC/sub-Centre may be suitably reduced so that family planning facilities, even for terminal methods, become available to all villages within bullock-cart distances.

11. Another finding of the study is that whereas 91.4 per cent of the sample adopters had been married and had their first child by the time the female partner was 25 years of age, only 21.9 per cent, i.e., a little over one

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fifth of these had begun to practise a family planning method by that time. Again from out of 935 sample adopters married by the age of 25 years, only 224, or 23.9 per cent, had adopted a family planning method by that age and the remaining 76.1 per cent had not done so. A prime target group of the family planning programmes should, therefore, be to reach all the couple in the age-group below 25 years.

12. Some of the other findings of the study are briefly recapitulated below :—

- (i) The actual deployment of family planning staff fell short of the sanctioned strength, particularly at the district and PHC levels. This indicated that the degree of organisational coordination was below the optimum and planned levels. The main reason for the posts remaining vacant was stated to be administrative delay.
- (ii) About 25 per cent of the Family Welfare Field and Evaluation Workers and 50 per cent of the Statistical Investigators at the district level and 20 to 22 per cent of Medical Officers, Block Extension Educators, Lady Health Visitors and Auxiliary Nurse/Midwives (ANMs) at the PHC level had not received any orientation training.
- (iii) The family planning programme had made better progress in bigger villages with better accessibility to medical health/facilities and having better infrastructural facilities.
- (iv) In the total sample for adopters, the proportion of female adopters was nearly twice that of male adopters.
- (v) Among the sample respondents canvassed the level of formal education as such came out as having little or no influence on the adoption of family planning measures.
- (vi) The percentage of adopters in different income brackets did not show any marked variations from the percentage of non-adopters in the corresponding income brackets. In other words, income levels had little or no determining influence on the adoption or otherwise of family planning measures. Adoption of family planning measures by eligible couples was due to factors other than that of income.
- (vii) Both the frequency of the use of different extension methods and the coverage of villages under them was generally quite high. As high as 88.3 per cent of total respondents were in contact with one or the other mass media. Of all the major mass media, radio emerged as the single most important medium.
- (viii) The involvement of villages and local leaders, school teachers, panchayats and voluntary organisations in the family planning work, in terms of actual help and comprehensive coverage of the selected villages, was woefully inadequate.
- (ix) Other things being the same, the length of the period of contact through audio, visual or personal media was of little or no significance in the adoption of family planning and the number of eligible couples adopting family planning was not contingent upon the duration of their awareness.
- (x) In the case of as high as 76.3 per cent of the adopters reporting time lags, the time-lags involved between awareness and adoption varied as widely as two to eight years and even more. The most important reason for the time-lag between awareness and acceptance as well as between acceptance and adoption, as given by 54.4 per cent and 35.8 per cent of the respective respondent adopters, was "fears and misconceptions".
- (xi) On an average an adopter had talked on the subject of adoption of family planning matters with 5.4 persons and about 80 per cent of these (4.3 persons) had followed the advice. This indicates that the adopters were helping in the spread of family planning and can play the role of good voluntary extension agents of the family planning programmes.

13. The credit for the finalisation of this study should deservedly go to one of our highly experienced officers, Shri R.K. Parashar, Deputy Adviser, Programme Evaluation Organisation. In addition to his own assignments he assumed the responsibility for this study from the nascent stage when its original Project Director superannuated. Under my supervision and guidance he painstakingly handled the onerous task of analysing and interpreting the data and information collected, carrying out the re-analysis and drafting modifications required at different stages and of preparing the final version of the report. Originally the Project Director of the study was Shri V.E. Easo, Deputy Adviser (Social Development) in the Programme Evaluation Organisation who, with the team of headquarters staff assisting him, namely, Shri Ashok Kumar, Research Officer, Sarvashri M. Nandi, R. K. Dash, C.A. Kadam, Economic Investigators Gr.—I and Shri Tara Dutt,

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Economic Investigator Grade-II, planned the design of the study, prepared the instruments of observation, coordinated the field work and drew up the tabulation plan for the data collected. However, Shri Easo could not complete the study by the time of his retirement in 1985. Stenographic assistance was provided by Shri S. P. Malhotra and Shri R. C. Grover. The processing of the data collected for the study was undertaken by the Computer Services Division of the Planning Commission who extended their fullest cooperation in this regard.

14. In obtaining the background information and material for this study the Programme Evaluation Organisation received valuable assistance from the Department of Family Welfare of the Union Ministry of Health and Family Welfare. The Family Welfare Departments of the concerned State Governments also gave their help to our field staff for conducting the study. Their assistance and cooperation is gratefully acknowledged.

15. It is hoped that this study will provide some insight into the working and operation of the several aspects of the family planning programme and prove useful not only to all those associated with the implementation of the programme but also researchers, social workers and others having an interest in this field and that its findings and recommendations will receive the due consideration of the Central and State Governments and thus be of some assistance in making this programme much more effective, inspirative and result-oriented.

NEW DELHI.  
28th May, 1986

Sd-/  
(G. P. KAPUR)  
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## Chapter 1

### INTRODUCTION

Point no. thirteen, of the New 20-Point Programme announced on January 14, 1982, stated that the Government would "promote family planning on a voluntary basis as a people's movement". The programme was expected to be pursued vigorously and promoted on a voluntary basis so as to develop it into a people's movement. In view of its importance, the Planning Commission desired the Programme Evaluation Organisation (PEO) to evaluate it. The present evaluation study was accordingly launched in the field by the PEO in January, 1983. (\*)

#### *Background*

1.02 The need to control population increase and to mitigate the adverse impact of population growth on the gains to be secured through economic development, was recognised by the planners since the very beginning of planning in the country. During the course of the First and Second Five Year Plans, the Family Planning Programme was, however, taken up only in a modest way. The emphasis was mainly on research in the field of demography, communication of the family planning message, physiology of reproduction and motivation. Family planning centres were established in some areas to provide 'clinical services', viz., facilities for vasectomy, tubectomy, IUD insertions, etc., and advice on family planning to those who came to seek it. During the Third Five Year Plan, the 'clinical approach' to the programme was supplemented by the 'extension approach'. Under the latter, family planning services and supplies of contraceptives were made available to the people on 'cafeteria basis', i.e., different family planning methods were made available to people to choose from. During the three Annual Plans (1966-69), the family planning programme was reorganised and made time-bound, target-oriented and provided with increased funds. A full-fledged department of family planning was created in 1966 at the Centre to give the programme central direction.

1.03 The Fourth Five Year Plan (1969-74) aimed at reducing the annual birth rate from 39 to 32 per thousand of population. Later, in April, 1976, i.e., during the Fifth Five Year Plan period (1974-79), the Union Health Minister, in a statement on National Population Policy, enunciated a new strategy of delivering an integrated package of Family Planning, Health and Maternal and Child Health (MCH) Services and Nutrition. This strategy was further linked with the Minimum Needs Programme (MNP). This shift in emphasis imparted a new focus to the family planning programme. The programme, however, received a set-back during the later part of the Fifth Five Year Plan period. The plan objective of reducing the birth-rate from 35 per thousand of population at the beginning of the Plan to 30 per thousand of population by 1978-79 could not be achieved. The level of effective family planning couple protection came down from 23.9 per cent in 1976-77 to 22.5 per cent in March, 1980. (1)

1.04 The Sixth Five Year Plan (1980-85) sought to identify the reasons for the set back to the programme during the Fifth Five Year Plan and also for the lack of appreciable progress in the earlier Plans. It was found that this was mainly due to the inability of the Government to carry forward the programme throughout the country with the active involvement of the people. It was also observed that the prevalent high rates of mortality in general, and the very high rate of infant mortality in particular, were inhibiting the acceptance of family planning and creating psychological barriers against the programme. The Sixth Five Year Plan, therefore, sought to achieve the objective of limiting the growth of population through the persuasion of people to adopt the 'small family' norm voluntarily and sought to back up the efforts in this direction by appropriate programmes of supplies and services for contraception. The Plan adopted the long-term demographic goal of reducing the Net Reproduction Rate (NRR) from the then existing 1.67 to 1.0 by 1995. (2). This implied that by that year (i) the average size of the family would be reduced from 4.2 children to 2.3 children; (ii) the birth rate per thousand population would be reduced from the level of 33 in 1978 to 21; (iii) the death rate per thousand population would be reduced from about 14 in 1978 to 9 and the infant mortality rate from 129 to 60 or less; and (iv) 60 per cent of eligible couples would be protected with family planning as against 22 per cent in 1975. (3).

(\*) The Programme Evaluation Organisation had evaluated the family planning programme, first in 1963-64 and again in 1969-70. The first of these evaluation studies was in the nature of a bench-mark study. The second study was conducted in two phases. The first phase was in the nature of a general purpose enquiry covering the availability of services, scope of the programme and nature of mass education and communication programme, staff position at different levels, the achievements, the assessment of knowledge, attitude and reaction of local leaders and general respondents functioning of Regional Training Centres etc. The second phase contained the study of adopters of vasectomy, tubectomy and IUD. The summary of main observation and suggestions of the first and the second evaluation studies is given in Annexure A and Annexure B respectively.

(1) Sixth Five Year Plan, 1980-85. Planning Commission p. 374, para 22.59

(2) Report of the Working Group on Population Policy, Planning Commission, May, 1980 (Paras 37-42).

(3) Sixth Five Year Plan 1980-85, p. 374 para 22-63.



## Evaluation Study

1.05 Keeping in view the focus provided by the strategy of family planning programme during the Sixth Five Year Plan and by the New 20-Point Programme, the objectives of the present evaluation study were decided upon as follows :

- (i) To study the organisational set up for the implementation of the programme, particularly for educating and motivating the people ;
- (ii) to examine the communication strategy adopted in term of creating awareness, change in attitude and adoption of family planning methods, and popularising the concept of 'small family' norms;
- (iii) to assess the extent of service facilities and supplies made available and their utilisation ;
- (iv) to understand the constraints experienced and problems faced in the implementation of the programme;
- (v) To assess the role played by voluntary organisations in promoting the programme as a people's movement, and
- (vi) to assess the views and reactions of the adopters and non-adopters towards family planning programme.

## Sample Design

1.06 The study was originally planned to cover 17 states in which field teams of the PEO were stationed. It could, however, be taken up in only 16 States, viz., Andhra Pradesh, Bihar, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Punjab, Rajasthan, Tamil Nadu, Uttar Pradesh and West Bengal. It could not be undertaken in Assam, because of the disturbed situation in the State at that time.

1.07 In each State, two districts, one 'progressive' and another 'non-progressive' were selected. Districts/PHCs having the maximum number of adopters per thousand of population in 1981-82 were taken as 'progressive' and those having the minimum number of adopters per thousand of population were taken as 'non-progressive'. (No uniform norm of adopters per thousand of population was applied in the selection of 'progressive' and 'non-progressive' districts/PHCs). The adoption figures per thousand of population (1981-Census) of each district in the selected States during 1981-82 were collected and serialised in the descending order and the districts with highest and lowest adoption figures were selected as 'progressive' and 'non-progressive' respectively. On the same criterion as for the selection of districts, two Primary Health Centres (PHCs)—one 'progressive' and the other 'non-progressive'—were selected from each district on the basis of adoption figures per thousand of population for 1981-82. From each selected PHC, two villages, one nearest to the PHC and the other farthest from it, considering the distance also from the neighbouring PHC, were chosen. The details of States, districts, PHCs and villages selected for this study are given in Annexure C.

## Selection of Respondents

1.08 The eligible couples<sup>1</sup> in the selected villages were categorised into three groups, viz., (a) adopters<sup>2</sup> of terminal methods<sup>3</sup>; (b) adopters of non-terminal methods<sup>4</sup> and (c) non-adopters<sup>5</sup> having at least two children. All the adopters in selected villages, practising any family planning method since April, 1980, as well as all eligible couples not practising any family method but having at least two children were included in the sampling frame for the selection of respondents. Five respondents from each of the above mentioned three categories were selected per village by random sampling method. If in a village the requisite minimum sample of respondents under a category was not available, the maximum number of respondents available in the respective category was selected.

(<sup>1</sup>) Eligible couples denote couples in whose case the wives are in the reproductive age group of 15-44 years regardless of the age of the husbands. (*Family Welfare Programme in India, Year Book 1981-82, Ministry of Health and Family Welfare, Government of India*)

(<sup>2</sup>) Adopters mean those practising any of the family planning methods.

(<sup>3</sup>) Terminal methods are those which provide permanent protection against conception viz. sterilisation—vasectomy for males and tubectomy for females.

(<sup>4</sup>) Non-terminal methods are those family planning methods which prevent conception so long as they are practised properly and regularly, e.g., IUD, oral pills, foam tablets, diaphragm, etc., for females and condom for males.

(<sup>5</sup>) Non-adopters are those eligible couples who do not practise any of the family planning methods.

## Coverage

1.09 The coverage and the sample of the study were, thus as follows:—

Units		No. selected
(a) States		16
(b) Districts		31
(c) PHCs		62
(d) Villages		124
(e) Respondents	(i) Adopters of terminal methods	585
	(ii) Adopters of non-terminal methods	439
	(iii) Non-adopters.	606
	(iv) Total (i) to (iii)	1630

## Reference Period

1.10 The data for the study was collected for the years 1980-81 and 1982-83. A major part of the field work for the study was undertaken during January-March, 1983.

## Instruments of Observation

1.11 The data were collected by using the following instruments of observation:

- (i) Proforma for selection of samples ;
- (ii) State/district/PHC level statements ;
- (iii) Village schedule ;
- (iv) Respondent schedule for adopters and non-adopters ; and
- (v) Guide points for qualitative notes.

1.12 In the Proforma for selection of samples, information was collected in respect of the number of adopters in the selected districts and PHCs for the year 1981-82, as also about the number of eligible couples and the couples adopting terminal and non-terminal methods since April, 1980 in the selected villages. Besides, information regarding the number of non-adopters in a village, having at least two children, was also collected. The secondary data were collected at State, district and PHC levels in three sets of statements.

1.13 The Village Level Schedule was designed to collect information, primarily from records and through discussions with local leaders, knowledgeable persons, panchayat officials and others, on aspects relevant to the programme, such as: (a) socio-economic and physical characteristics of the selected villages; (b) various amenities and facilities available in them; (c) extension efforts at the village level for the promotion of family planning programme; (d) visits to the village by the family planning staff; (e) medical and family planning facilities accessible to eligible couples in the villages adopting different family planning methods; (f) role of local leaders, voluntary organisations, local bodies, etc., in the implementation of the family planning programme; and (g) views and suggestions of the selected respondents.

1.14 Through the Respondent Schedule, primary data were obtained from the selected adopters (beneficiaries of the family planning programme as well as from non-adopters. The Schedule was divided into three parts, the first part being common to all the respondents followed by two separate parts; one relevant to adopters and the other to non-adopters only. The first part contained mainly questions on socio-economic, cultural and family data of the respondent households. The second part for adopters was designed to elicit information from them in detail about the process of knowledge, acceptance and adoption of family planning programme by them as well as their views and reactions on major components of the programme. In the last part of the Schedule, data were sought to be collected from only the non-adopters. Besides data on their knowledge about family planning programme and its benefits, information was obtained in respect of the reasons for their non-adoption, and suggestions on additional or supportive elements or environment that would make them adopt the programme.

1.15 The Guide points for qualitative notes mainly covered the progress of the family planning programme over the plan periods, efforts made during the Sixth Five Year Plan to accelerate the programme, problems faced in implementation and suggestion for more effective implementation of the programme in States/districts/PHCs and villages.

## Chapter 2

### ORGANISATIONAL SET-UP

The organisational set-up for the implementation of the Family Planning Programme at the time of the study was a four-tier set-up. As would be seen from Annexure D at the apex, i.e., at the Centre, there was a Department of Family Welfare in the Ministry of Health and Family Welfare. At the State level, the programme was planned and directed by the Family Welfare Bureau of the Directorate of Family Welfare. Besides the Bureau, the State Family Welfare Cell coordinated the family welfare activities between the Central Government and the States. At the district level, the District Family Welfare Bureau directed and coordinated the activities relating to family planning within the district. In each block of a district, there was a Primary Health Centre (PHC), with a Rural Family Welfare Centre as an integral part of it. Each Primary Health Centre was supported by sub-Centres at the village level. Upto the end of the Fifth Five Year Plan, one sub-Centre had been provided to cover 10,000 rural population. However, in the Sixth Five Year Plan, the Planning Commission approved the establishment of one sub-Centre for 5000 of rural population.

#### Staffing Pattern

2.02 *State Level*: According to the envisaged staffing pattern of the Family Welfare Bureau, an Additional Director/Joint Director/Deputy Director was to be incharge of the Family Welfare Programme at the State level. However, the actual set-up obtaining in different States varied in the matter of both staff levels and staff designations. For instance, in the case of Maharashtra, an Additional Family Welfare Commissioner was heading the programme, whereas a Director was incharge in four States, namely, Andhra Pradesh, Himachal Pradesh, Madhya Pradesh and Orissa. An Additional Director was looking after the programme in five States, viz., Bihar, Karnataka, Kerala, Rajasthan and Uttar Pradesh. A Joint Director was the Chief executive of the programme in Haryana, Punjab and West Bengal whereas a Deputy Director was in-charge in the States of Gujarat, Jammu & Kashmir and Tamil Nadu.

2.03 The Family Welfare Bureau at the State level was organised into Divisions, such as Education and Information Divisions, Operation, Planning and Training Division, Demographic and Evaluation Cell, besides the usual Administration and Accounts Branches. Annexure E sets out the broad outline of Family Welfare Bureaux in States. The State-wise details of the technical staff sanctioned and in position in the year 1982-83, in the 16 States in which the study was conducted, are given in Appendix table 2.1. Appendix table 2.2 gives the consolidated position in this regard.

2.04 It will be seen from Appendix table 2.2 that in the 16 States taken up for this study, out of the 250 sanctioned technical posts, 227 staff, i.e., 90.8 per cent, were in position as on 31st March, 1983. Generally, all the senior level posts were found to be filled up in all States. The number of posts lying vacant was relatively high in the case of posts of Social Scientists (3 out of 12), Family Welfare Field and Evaluation Worker (11 out of 48) and Exhibition/Outdoor Publicity/Audio-Visual Officer (3 out of 14). In other words, in the case of these three categories of officials, 22 to 25 per cent of the posts had not been filled up.

2.05 At the State level, considerable variation was also noticed in the number of posts sanctioned in certain categories of staff. Thus, the number of sanctioned posts of Deputy Director varied from one each in Gujarat, Jammu and Kashmir, Rajasthan, Tamil Nadu and Uttar Pradesh, to two in Madhya Pradesh, three in Bihar and Himachal Pradesh, four in Karnataka, five in Orissa and nine in Maharashtra. The number of sanctioned posts of Assistant Director ranged from one each in Gujarat and Rajasthan to two in Haryana, Jammu and Kashmir and West Bengal, three in Punjab and Tamil Nadu, five in Himachal Pradesh and eight in Maharashtra. In the case of the posts of Exhibition/Outdoor Publicity/Audio-Visual Officer, two each were sanctioned in Gujarat, Haryana and Rajasthan, while there was only one post each in eight States, viz., Bihar, Himachal Pradesh, Jammu & Kashmir, Karnataka, Madhya Pradesh, Maharashtra, Uttar Pradesh and West Bengal. In the remaining five States, viz., Andhra Pradesh, Kerala, Orissa, Punjab and Tamil Nadu, there was no such post. Posts of Statistical Officer/Statistician varied from one each in five States, viz., Andhra Pradesh, Bihar, Jammu & Kashmir, Tamil Nadu and Uttar Pradesh to two each in nine States, viz., Gujarat, Himachal Pradesh, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Punjab, Rajasthan and West Bengal. Haryana and Kerala did not report this post.

2.06 In the case of junior level posts, such as Statistical Investigators and Family Welfare Field and Evaluation Workers, the variation observed in the number of sanctioned posts was larger. While in Kerala four and in Rajasthan 11 posts of Statistical Investigators were sanctioned, in nine States there was only one such post.

Himachal Pradesh and Karnataka had two posts of Statistical Assistants and Rajasthan three. However, each of the eight States, *viz.*, Andhra Pradesh, Bihar, Gujarat, Jammu & Kashmir, Madhya Pradesh, Orissa, Tamil Nadu and West Bengal had only one post. In the remaining five States, there was no such post. The number of posts of Family Welfare Field and Evaluation Worker was one in Kerala, three in Jammu and Kashmir, four in Orissa, seven in Tamil Nadu, nine in Gujarat and 10 in Andhra Pradesh. The remaining nine States did not report about this post.

2.07 *District Level*: At the district level, the staff generally consisted of a District Family Welfare Officer assisted by District Mass Education and Media Officer and District Extension Educator. The supplementary staff comprised Statistical Investigator/Assistant and Family Welfare Field and Evaluation Worker. The State-wise position regarding staffing pattern in the districts studied in each State is given in Appendix table 2.3.

2.08 The following table gives the consolidated staff position as on 31st March, 1983 for 27 out of the 31 selected districts. The information in respect of four districts, *viz.*, Budgam (Jammu & Kashmir), Rewa (Madhya Pradesh), Ramnad (Tamil Nadu) and Howrah (West Bengal) could not be obtained.

Table 2.1—*Technical Staff Sanctioned and in Position at District Level in the Selected Districts as on 31st March, 1983.*

Category of Staff (Designation)	No. of posts		
	Sanctioned	In position	Percentage
1	2	3	4
1. District Family Welfare Officer.	27	25	92.6
2. District Mass Education and Media Officer.	42	35	83.3
3. District Extension Educator	26	18	69.2
4. Statistical Investigator/Statistical Assistant.	27	23	85.2
5. Family Welfare Field and Evaluation Worker.	6	4	66.7
Total	128	105	82.0

N.B. Information is in respect of 27 reporting districts.

2.09 As against 9.2 per cent of posts lying vacant at the State level (Appendix table 2.2), almost double the percentage (18%) of the posts was found to be vacant at the district level (table above). The vacancies were highest in the category of Family Welfare Field and Evaluation Workers and District Extension Educators, being as high as 33 per cent and 31 per cent, respectively. This was a rather high incidence of vacancies. In the case of two out of the 27 districts (Gulbarga district in Karnataka and Faridkot district in Punjab), the post of even the top functionary, *viz.*, the District Family Welfare Officer, was found to be vacant.

2.10 *Block/Primary Health Centre (PHC) Level*: At the Primary Health Centre level, one Medical Officer, assisted by a Block Extension Educator and Lady Health Visitor, was responsible for the implementation of the programme. The village level staff consisted of an Auxiliary Nurse-Midwife (ANM), Family Welfare Health Assistant and a Multipurpose Worker. The details in respect of four PHCs selected in each State (except in Orissa where there were two) are given in Appendix table 2.4.

2.11 The consolidated position as regards the technical staff sanctioned and in position in the 62 selected Primary Health Centres was as shown in the table below :

Table 2.2 Technical Staff Sanctioned and in Position in the 62 Selected PHCs as on 31st March, 1983

Category of staff (Designation)	No. of Posts		
	Sanctioned	In position	Percentage
1	2	3	4
1. Medical Officer . . . . .	63	57	90.5
2. Block Extension Educator . . . . .	63	55	87.3
3. Lady Health Visitor/Health Supervisor . . . . .	122	97	79.5
4. Auxiliary Nurse-Mid Wife . . . . .	440	377	85.7
5. Family Welfare Health Assistant . . . . .	92	82	89.1
6. Multipurpose Worker . . . . .	370	288	77.8
7. Computer . . . . .	48	46	95.8
<b>TOTAL . . . . .</b>	<b>1198</b>	<b>1002</b>	<b>83.6</b>

2.12 It was found that the selected PHCs in Andhra Pradesh only were fully staffed, whereas those in Bihar, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Kerala, Maharashtra and Tamil Nadu were well staffed, the staff in position ranging between 90 and 98 per cent of the sanctioned strength. However, the selected PHCs in Rajasthan and Uttar Pradesh were poorly staffed with in position staff at 54 per cent and 56 per cent respectively.

2.13 The consolidated percentage of vacancies of all the categories of posts at the primary Health Centre Level worked out to 16.4 which was only marginally lower than that at the district level (18%). The highest percentage of vacancies (22.2%) was in respect of the posts of Multipurpose worker followed by Lady Health Visitor/Health Supervisor (20.5%). About 14 per cent of the posts of Auxiliary Nurse-Mid Wife (ANMs) and 10 per cent of the posts of Medical Officers were also vacant. The posts of Multipurpose Workers were mostly vacant in Uttar Pradesh, Karnataka, Punjab and Orissa. The vacancies in the posts of Lady Health Visitor were mainly in Haryana, Kerala, Maharashtra, Rajasthan and Uttar Pradesh and one each in Bihar, Gujarat, Jammu & Kashmir, Karnataka and West Bengal. The posts of Auxiliary Nurse-Mid Wife were largely vacant in Gujarat, Madhya Pradesh, Rajasthan, Uttar Pradesh and West Bengal.

2.14 A broad comparison of the staff in position and the sanctioned strength at various levels, i.e., State, District and Primary Health Centre, as observed at the time of the earlier evaluation study of the programme by the PEO in 1969-70 and during the present study, indicated that the position seemed to have somewhat improved at all the levels. At the State level, the staff in position as a proportion of the sanctioned strength improved from 77.5 per cent in 1969-70 to 90.8 per cent in 1982-83. Similarly, at the district level, this proportion rose from 67 per cent to 82 per cent and at the Primary Health Centre level from 75.0 per cent to 83.6 per cent. These comparisons, it may be noted, are of a broad nature, as the districts/Primary Health Centres, etc., selected for the two evaluation studies were different and there were also some variations in the categories of staff employed at these levels at the time these studies were undertaken. The 1969-70 evaluation study had covered all the then existing 16 States and one of the Union Territories and had covered 35 districts, 69 Family Planning Centres and 65 Regional Training Centres. At the level of the State Family Planning Bureau in most cases the staff included Joint Director/Deputy Director, Asstt. Director, Administrative Officer, Medical Officer Incharge IUCD, Health Education Officer, Statistician, Asstt. Editor, Statistical Assistant, Artist-cum-photographer and Stores Officer. At the level of the district Family Planning Bureau the staff generally comprised Distt. Family Planning Officer, Asstt. Surgeon (Grade-I) (Male) for sterilisation, Asstt. Surgeon (Grade-I) (Female) for IUCD, Mass Education Information Officer, Distt. Extension Educator (Male), Distt. Education Educator (Female), Family Planning Field Worker (Male), Family Planning Field Worker (Female), Operation Theatre Nurse, Auxiliary Nurse-Midwife and Projectionist. The coverage under the present study is confined to only 16 out of the 22 State

of the Union Territories has been covered under the present study. In the 16 selected States, 31 districts and 62 PHCs (Public Health Centres) have been studied. The staffing pattern at the State level was as given at Annexure E. Appendix tables 2.3 and 2.4 give the staffing pattern at the district and the PHC levels.

2.15 The phenomenon of actual deployment of staff falling short of the sanctioned strength, particularly at the district and PHC levels, indicated that the degree of organisational coordination remained below the optimum and planned levels. The sizeable number of posts in all categories lying vacant at the district level were a drag on the full-scale implementation of the programme, as either some portion of the work to be looked after by the incumbents of these posts accumulated or, as in the case of field staff, the areas to be covered by them remained inadequately attended or unattended. Similarly, the vacancies in the middle and lower categories of posts at the PHC level, such as those of the Lady Health Visitor and Auxiliary Nurse-Mid Wife, meant that the services which would have been provided, if the incumbents were in position, were in fact not made available. Appropriate action to remove this deficiency is, therefore, called for by the States concerned.

### **Reasons for Posts Remaining Vacant**

2.16 The main reason for the posts remaining vacant at different levels was stated to be administrative delay. The process of recruitment (it was reported) was usually slow and time consuming. In some cases, the posts were held in abeyance or a ban was imposed on filling up the vacant posts as an economy measure. In other cases, the posts remained vacant due to the non-availability of suitable candidates i.e., candidates fulfilling the required qualifications.

2.17 In as much as the successful implementation of a crucial programme of national importance, like Family Welfare Programme, rests to a large extent on the full complement of staff being in position at all levels, it is imperative that ways and means should be found to cut down administrative delays in the filling up of the posts.

2.18 The adequacy of the existing staff structure for the implementation of the programme was discussed with the concerned officials at the State/District and PHC levels. In nine out of the 16 selected States (Andhra Pradesh, Haryana, Himachal Pradesh, Karnataka, Kerala, Punjab, Rajasthan, Uttar Pradesh and West Bengal), the view was expressed that the existing family planning staff at different levels, particularly at the district and lower levels, was inadequate. The concerned officials emphasised the need for strengthening the staff at the district/PHC levels keeping in view the size of the population to be serviced and the communication facilities available. Therefore, keeping in view the magnitude of the population to be serviced and the terrain and communication facilities available, the State Governments should review the strength of the staff required for the purpose at different levels of the operation of the programme and accordingly take steps to strengthen it. Creation of posts alone, is however, not adequate. Available posts, new or on transfer, should be filled up expeditiously. The district and junior level posts, being operational level posts, should be filled up with a sense of urgency. It should be the endeavour to fill up the posts falling vacant within an outer limit of three months.

### **Training of Family Planning Staff**

2.19 The training of the staff in the basic technical and administrative aspects of a programme has a key importance for the successful implementation of any social development programme. This is particularly so for a programme like Family Planning, having medical, socio-psychological and cultural implications. The family planning staff should, therefore, have proper and adequate training so as to enable them to project the programme effectively and also to cater to the needs and requirements of eligible couples having different socio-cultural background as well as psychological attitudes. Keeping this aspect in view, information was collected on the orientation and in-service training undergone by the family planning staff in position at various levels at the time of the study.

2.20 *State Level* : At the State level, as on 31st March, 1983, information regarding special training in family welfare, if any, undergone by the technical staff was available in respect of 172 out of 227 officials. Of these, 136 (79.1%) had undergone training. Almost all of the higher level officers had received the training. It was mostly in the case of junior level officers, like Family Welfare Field and Evaluation Workers (42.4%) and those in the Statistical and Demographic wings, that it was found that the concerned staff had not undergone any special training. Appendix table 2.5 sets out the summary position regarding officers of various categories working in the concerned State level organisations who had received training.

2.21 *District Level* : Out of 105 technical officers of various categories in position at the district level in 1982-83, information regarding training in respect of three officers (two District Family Welfare Officers and one

Statistical Investigator) was not available. The position regarding the training status of the remaining 102 technical staff is brought out in the following table.

Table 2.3 *Number of Technical Staff at District Level (27 Districts) and Number Trained in Family Welfare (1982-83)*

Category of Staff (Designation)	Training of Staff		
	No. reporting	No. trained	Percentage trained
1	2	3	4
1. District Family Welfare Officer . . . . .	23	21	91.0
2. District Mass Education and Media Officer . . . . .	35	32	91.4
3. District Extension Educator . . . . .	18	17	94.4
4. Statistical Investigator/Statistical Assistant . . . . .	22	11	50.0
5. Family Welfare Field and Evaluation Worker . . . . .	4	3	75.0
<b>TOTAL</b> . . . . .	102	84	82.4

2.22 It will be observed from Appendix table 2.5 and table 2.3 above that over 79 per cent of the staff at the State level and over 82 per cent at the district level had undergone special training in family welfare programme. However, about 25 per cent of the Family Welfare Field and Evaluation Workers and 50 per cent of the Statistical Investigators at the district level had not received any training. These categories of staff also need training in the programme, perhaps even more than the higher level staff. Therefore, in order to equip the field level staff to discharge their assignments proficiently, they should be given the requisite training.

2.23 *Primary Health Centre Level* : Out of the 1002 technical staff of all categories in position at the 62 selected PHCs, 778 (77.6%) were reported to have undergone one or the other type of in-service or orientation training in family welfare programme. In the sample studied 20 to 22 per cent of Medical Officers, Block Extension Educators, Lady Health Visitors, Multipurpose Workers and ANMs had yet to receive any orientation training. The following table gives the category-wise number of staff in position and of those among them who had been trained.

Table 2.4 *Number of Technical Staff in Position at PHC Level (62 PHCs) and Number Trained in Family Welfare (1982-83)*

Category of Staff (Designation)	Training of Staff		
	No. in position	No. trained	Percentage trained
1			
1. Medical Officer . . . . .	57	45	78.9
2. Block Extension Educator . . . . .	55	43	78.2
3. Lady Health Visitor/Health Supervisor . . . . .	97	78	80.4
4. Auxiliary Nurse-Mid-Wife (ANM) . . . . .	377	301	79.8
5. Family Welfare Health Assistant . . . . .	82	79	96.3
6. Multipurpose Worker . . . . .	288	219	76.0
7. Computer . . . . .	46	13	28.3
<b>TOTAL</b> . . . . .	1002	778	77.6

2.24 The training status of some of the key functionaries of the programme at the district and Primary Health Centre levels observed during the course of the present study could broadly be compared with that at the time of the earlier evaluation undertaken by the PEO in 1969-70. The comparative data are presented in the following table.

Table 2.5 *Percentage of Technical Staff Trained at District and PHC Levels as Found in the Earlier Study (1969-70) and the Present Study (1982-83)*

Category of Staff (Designation)	Percentage of staff trained			
	Earlier Study (1969-70)		Present Study (1982-83)	
	District Level	PHC Level	District Level	PHC Level
1	2	3	4	5
1. District Family Planning Officer. . . . .	44.4	—	91.0	—
2. District Mass Education and Information Officer . . . . .	45.8	—	91.4	—
3. District Extension Educator . . . . .	71.4	—	94.4	—
4. Medical Officer . . . . .	—	52.0	—	78.9
5. Block Extension Educator . . . . .	—	78.0	—	78.2
6. Lady Health Visitor . . . . .	—	67.0	—	80.4
7. Family Welfare Health Assistant . . . . .	—	61.0	—	79.8
	—	65.0	—	84.2

2.25 It will be seen from the above table that in 1969-70 at the district level, the number of officials trained ranged from about 44.4 per cent in case of District Family Planning Officers and 45.8 per cent in the case of Mass Education and Information Officers to 71.4 per cent in the case of District Extension Educators. On the other hand, it was found during the present study that 91.0 per cent to 94.4 per cent of these categories of officers in position were trained. A similar trend was noticed at the Primary Health Centre level also. While the percentage of the important categories of staff, such as Medical Officer, Block Extension Educator, Lady Health Visitor and Family Welfare Health Assistants trained at the Primary Health Centre level in 1969-70 was 65.0 per cent, it rose to 84.2 per cent by the time of the present study in 1982-83.

2.26 Notwithstanding the increase in recent years in the number of family planning staff that have undergone training, for the successful implementation of the programme all officers concerned, particularly those at the junior levels, should be given suitable and adequate training, in respect of both the background and concepts of the programme and methods and techniques of implementation. In fact, in the case of junior level staff the coverage under training should be cent per cent. The required training needs to be imparted not only at the time of first appointment and posting but also at regular intervals. For this purpose, it may be desirable to prepare a long-term roster of training, in respect of all categories of staff, so that the staff can be sent in batches on rotation without affecting the normal working of the programme in the field. In fact, all States should have a permanent training institute, where different level staff could be sent for initial training and subsequent refresher and reorientation courses from time to time in their service career. Besides, at reasonable intervals, the field staff should be provided opportunity to discuss and share their experiences of programme implementation amongst themselves in short duration seminars, workshops, group discussions, etc.



## Chapter 3

### SAMPLE VILLAGES AND RESPONDENTS

The characteristics of the sample villages and sample household respondents selected for this study are analysed in this chapter. The analysis of aspects, such as area, population accessibility and availability of medical facilities in the case of villages, and of age, sex, educational, cultural, social, occupational and income characteristics in the case of sample household respondents together with the family planning methods adopted by them, would, it is hoped, furnish an idea of the socio-economic milieu in which the family planning programme was being implemented and also provide some insight into the influence such characteristics had on the progress of the programme in the selected districts.

#### Characteristics of Sample Villages

3.02 *Size of the Villages*—It would be seen from table 3.1 that 59.7 per cent, i.e., 74 out of the 124 villages, had an area of less than five sq. kms., 26.6 per cent between 5 and 10 sq. kms. and 13.7 per cent 10sq. kms. and above. The distribution of villages by area did not show any significant variation between progressive and non-progressive districts.\*

Table 3.1 : *Distribution of Selected Villages by Area*

Types of districts	No. of sample villages	No. of villages reporting /Area (Sq. kms.)				
		Less than 3	3 to less than 5	5 to less than 10	10 to less than 20	20 and above
1	2	3	4	5	6	7
Progressive . . . . .	60	23(38.3)	11(18.3)	18(30.0)	4(6.7)	4(6.7)
Non-Progressive . . . . .	64	26(40.6)	14(21.9)	15(23.4)	4(6.3)	5(7.8)
All Districts . . . . .	124 (100.0)	49(39.5)	25(20.2)	33(26.6)	8(6.4)	9(7.3)

N.B.—Figures in brackets are percentages.

3.03 *Size of Population*—Table 3.2 gives the distribution of selected villages by population size. It would be seen therefrom that 56.4 per cent of the villages had a population of less than 2,000, of which 30.6 per cent had a population below 1,000. Only about 16 per cent of the villages had a population of over 5,000. Further, while the largest percentage of villages from progressive districts was in the population range of 2000—5000, the largest percentage of villages from non-progressive districts had less than 1000 of population.

Table 3.2. : *Distribution of Villages by Population Size*

Types of districts	No. of sample villages	No. of villages reporting population of				
		Less than 1000.	1,000 to 1,999.	2,000 to 4,999	5,000 to 9,999	10,000 and above
Progressive . . . . .	60	17(28.3)	14(23.3)	21(35.0)	4(6.7)	4(6.7)
Non-Progressive . . . . .	64	21(32.8)	18(28.2)	13(20.3)	7(10.9)	5(7.8)
All Districts . . . . .	124(100.0)	38(30.6)	32(25.8)	34(27.4)	11(8.9)	9(7.3)

N.B.—Figures in brackets are percentages.

\*For the definition of 'Progressive' and 'non-progressive' districts, see para 1.07.

3.04 *Accessibility*—Of the total number of villages taken up for this study, 49.2 per cent were connected by pucca roads and another 40.3 per cent had only kutchra roads as connecting links. As between progressive and non-progressive districts, whereas 51.7 per cent of the sample villages from the former had pucca road links, only 46.9 per cent from among the latter had pucca connecting roads. Further, as would be seen from table 3.3, whereas 35.0 per cent of the villages from progressive districts had kutchra road links only, in the case of sample villages from non-progressive districts this percentage was as high as 45.3. Also, as against nil number from progressive districts, over six per cent of the sample villages from non-progressive districts were accessible only by bridle path.

Table 3.3 : *Accessibility of the Sample Villages.*

Types of districts	No. of sample villages	No. of villages reporting/Type of connecting roads			
		Pucca roads	Kutchra roads	Mixed (Pucca/Kutchra) roads	Bridle Path
1	2	3	4	5	6
Progressive . . . . .	60	31(51.7)	21(35.0)	8(13.3)	0(0.0)
Non-Progressive . . . . .	64	30(46.9)	29(45.3)	1(1.6)	4(6.2)
	124(100.0)	61(49.2)	50(40.3)	9(7.3)	4(3.2)

N.B.—Figures in brackets are percentages.

3.05 *Availability of Educational, Recreational, Communication and Transport Facilities*—Educational facilities (primary, middle and secondary school levels), entertainment facilities by way of cinema halls, and facilities of communication and transport were, by and large, available in an almost the same proportion in the selected villages from progressive and non-progressive districts. The position regarding the availability of each type of facility to the villages from the two groups of districts is brought out in the following table.

Table 3.4 : *Distribution of Selected Villages by Infrastructural Facilities Available*

Facilities	No. of villages reporting from :	
	Progressive districts	Non-progressive districts
1	2	3
1. Primary School . . . . .	53(88.3)	61(95.3)
2. Middle School . . . . .	35(58.3)	34(53.1)
3. Secondary School . . . . .	16(26.7)	15(23.4)
4. Cinema Hall . . . . .	5(8.5)	5(7.8)
5. Post Office . . . . .	38(63.3)	40(62.5)
6. Bus - stop . . . . .	39(65.0)	40(61.5)
7. Railway Station . . . . .	3(5.0)	
Total No. of villages . . . . .	60(100.0)	64(100.0)

N.B.—Figures in brackets are percentages.

**3.06 Availability of Health/Medical Facilities**—Appendix table 3.1 sets out the data pertaining to the location/distance of hospitals/dispensaries in respect of the selected villages in the progressive as well as non-progressive districts. It will be seen from these data that a hospital run by either government or local or private bodies was located in the village itself in 10.0 per cent of the selected villages from progressive districts and 6.2 per cent of the villages in non-progressive districts. In another 26.7 per cent of the villages in the progressive districts and 18.8 per cent of the villages in non-progressive districts, there was a hospital within a distance of less than five kms. The selected villages from progressive districts were likewise generally better placed in the matter of location of dispensaries, availability of private medical practitioners and trained midwives/dais. As brought out by the data given in Appendix table 3.1, dispensaries were located in the villages themselves or within 5 kms. distance from them in 63.3 per cent of sample villages in progressive districts as against 43.8 per cent of the villages in non-progressive districts; private medical practitioners were there in 85.0 per cent of sample villages from progressive districts as against 60.1 per cent from non-progressive districts; and trained midwives/dais were available in 90.0 per cent of sample villages from progressive districts as against 70.3 per cent from non-progressive districts. In short, the selected villages from progressive districts were much better placed in the matter of availability of health/medical facilities. This suggests that the extent of the spread and adoption of family planning in the selected villages was directly related to the availability of health/medical facilities.

**3.07** This is further brought out by the distribution of the selected villages by distance from PHCs and sub-Centres. It would be observed from table 3.5 that whereas 46.7 per cent of sample villages from progressive districts had a PHC within 5 kms. distance from them, only 35.9 per cent of sample villages from non-progressive districts had a PHC located within this distance. However, in the matter of distance from sub-Centres there was in the overall no marked difference as between the sample villages from progressive districts and those from non-progressive districts.

TABLE 3.5 : Distribution of Selected Villages by Distance from PHCs and Sub-Centres

Distance/Range (Kms.)	PHCs		Sub-Centre	
	Sample villages from progressive districts (N = 60)	Sample villages from non-progressive districts (N = 64)	Sample villages from progressive districts (N = 60)	Sample villages from non-progressive districts (N = 64)
1	2	3	4	5
Within the village . . . . .	4 (6.7)	5 (7.8)	40 (66.7)	40 (62.5)
Upto 5 Kms. . . . .	24 (40.0)	18 (28.1)	11 (18.3)	15 (23.4)
5 to 10 Kms. . . . .	5 (8.3)	9 (14.1)	6 (10.0)	8 (12.5)
10 Kms. & more . . . . .	27 (45.0)	32 (50.0)	3 (5.0)	1 (1.6)

N.B. —Figures in brackets are percentages.

**3.08** To sum up, the foregoing analysis suggests that in as much as a larger number of sample villages from progressive than in non-progressive districts\* were better placed in respect of their size (area as well as population), accessibility and availability of infrastructural facilities, such as education, recreation, communication, transport, health/medicine, the extent of the spread of family planning in the sample villages from progressive districts was also better. In other words the family planning programme had made a better progress in bigger villages with better accessibility to medical/health facilities and having better infrastructural facilities. Therefore, in order to obtain faster results the efforts under the family planning programme should be directed in a greater measure to villages of a bigger size and comparatively better served with infrastructural facilities of the type referred to earlier. At the same time, this analysis also suggests that the greater provision of amenities and infrastructural facilities in the villages would provide a positive support to the wider spread and adoption of this programme.

#### Profile of Sample Household Respondents

**3.09** To turn to the profile of the selected household respondents, in what follows their distribution is analysed by (i) age-groups, (ii) sex, (iii) cultural groups, (iv) social groups, (v) educational levels, (vi) occupational groups, and (vii) income levels.

\*For the definition of 'progressive' as well as 'non-progressive' districts see para 1.07

3.10 *Distribution by Age*—The age-wise distribution of the selected sample respondents is shown in table 3.6. It will be seen therefrom that the highest proportion (51.9 per cent) of the total number of respondents canvassed was in the age-group 25-34 years followed by the age-group 35-44 years (33.6 per cent). The age-groups 15-24 years and 45 years and above accounted for only 8.7 and 5.8 per cent, respectively, of the total number of respondents canvassed. As against this the highest proportion of adopters (78 per cent) as on the date of canvassing, was in the respondents in the age-group 15-24 years, followed by the age-group 25-34 years (71.4 per cent). In the higher age-groups the percentage of adopters exhibited a sharp decline and that of non-adopters correspondingly increased steeply.

Table 3.6 : *Distribution of Selected (Household) Respondents by Age Groups*

Age Group	Total No. canvassed		Adopters		Non-adopters	
	Total No.	As % age of Col. 2	Total No.	As % age of col. 2	Total No.	As % age of col. 2
1	2	3	4	5	6	7
1. 15-24 years . . . . .	141	8.7	110	78.0	31	22.0
2. 25-34 years . . . . .	846	51.9	604	71.4	242	28.6
3. 35-44 years . . . . .	548	33.6	283	51.6	265	48.4
4. 45 years and above . . . . .	95	5.8	27	28.4	68	71.6
Total . . . . .	1630	100.0	1024	62.8	606	37.2

3.11 *Distribution by Sex*—As the family planning programme covers both males and females (through different types of family planning methods), the adopters among the sample respondents belonged to both sexes. Table 3.7 gives the distribution of sample respondents (adopters as well as non-adopters) by sex. Out of 1024 sample adopters 664 or 64.85 per cent, were females and the remaining 360 or 35.15 per cent, were males. From out of 585 adopters of terminal methods 483, or 82.57 per cent, were females and 102, i.e., 17.43 per cent, were males. Among the 439 sample adopters using non-terminal methods, however, 258, or 58.76 per cent, were males and the remaining 181, i.e., 41.24 per cent, were females. Thus, in the total sample for adopters, the proportion of female adopters was nearly twice that of male adopters. This, *inter alia*, suggests the need for reaching out to the male population of rural areas in a greater measure.

Table 3.7 : *Distribution of Adopters and Non-adopters by Sex*

Sex	No. of Adopters			No. of non adopters	Total
	Using terminal methods	Using non-terminal methods	Total		
1	2	3	4	5	6
1. Male . . . . .	102 (17.43)	258 (58.76)	360 (35.15)	501 (82.67)	861 (52.82)
2. Female . . . . .	483 (82.57)	181 (41.24)	664 (64.85)	105 (17.33)	769 (47.18)
3. Total No. . . . .	585 (100.00)	439 (100.00)	1024 (100.00)	606 (100.00)	1630 (100.00)

N.B. - Figures in brackets are percentages.

3.12 *Cultural Groups*—The distribution of sample adopters and non-adopters by cultural groups is set forth in table 3.8. It will be seen from this table that whereas in the case of Hindus and Muslims the proportion of non-adopters was slightly higher than that of adopters, in the case of Christians and Sikhs the proportion of non-adopters was distinctly lower than that of adopters in the respective samples.

Table 3.8 : *Distribution of Adopters and Non-adopters by Cultural Groups*

Cultural Groups	Adopters	Non-Adopters	Total number
1	2	3	4
1. Hindus . . . . .	847 (82.7)	515 (85.0)	1362 (83.6)
2. Muslims . . . . .	85 (8.3)	56 (9.2)	141 (8.7)
3. Christians . . . . .	20 (2.0)	5 (0.8)	25 (1.5)
4. Sikhs . . . . .	64 (6.3)	30 (5.0)	94 (5.8)
5. Others . . . . .	8 (0.8)	0 (0.00)	8 (0.5)
Total . . . . .	1024 (100.0)	606 (100.0)	1630 (100.0)

N.B. Figures in brackets are percentages.

3.13 Table 3.9 shows the distribution of the sample adopters of terminal and non-terminal methods by cultural groups. It will be observed from this table the proportions of adopters using terminal and non-terminal methods among different cultural groups did not show any significant variation indicating that while adopters from all the cultural groups were using terminal as well as non-terminal methods the information gathered did not show any distinct preference within a cultural group for any one of the two types of methods.

Table 3.9 : *Distribution of Adopters by Cultural Groups and the Family Planning Methods Used*

Cultural groups	No. of Adopters		Total
	Terminal methods	Non-terminal methods	
1	2	3	4
1. Hindus . . . . .	488 (83.41)	359 (81.77)	847 (82.71)
2. Muslims . . . . .	46 (7.86)	39 (8.88)	85 (8.30)
3. Christians . . . . .	10 (1.70)	10 (2.28)	20 (1.95)
4. Sikhs . . . . .	37 (6.33)	27 (6.11)	64 (6.25)
5. Others . . . . .	4 (0.70)	4 (0.92)	8 (0.78)
Total . . . . .	585 (100.00)	439 (100.00)	1024 (100.00)

N.B.—Figures in brackets are percentages.

3.14 *Social Groups*—Out of 1630 household respondents canvassed, 355 (20.6%) were from scheduled castes, 367 (22.5%) from backward classes, 54 (3.3%) from scheduled tribes, and the remaining 874 (53.6%) from the residual category of 'others'. The distribution of the sample adopters of terminal and non-terminal methods and non-adopters by social groups is shown in table 3.10.

Table 3-10 : *Distribution of Adopters and Non-adopters by Social Groups*

Social groups	Adopters			Non-adopters	Total
	Terminal methods	Non-terminal methods	Total		
1	2	3	4	5	6
1. Scheduled castes . . . . .	136 (23·24)	68 (15·48)	204 (19·92)	131 (21·61)	335 (20·55)
2. Scheduled tribes . . . . .	12 (2·05)	7 (1·59)	19 (1·85)	35 (5·78)	54 (3·31)
3. Backward classes . . . . .	144 (24·61)	81 (18·46)	225 (21·97)	142 (23·43)	367 (22·52)
4. Others . . . . .	293 (50·10)	283 (64·47)	576 (56·26)	298 (49·18)	874 (53·62)
Total : . . . . .	585 (100·00)	439 (100·00)	1024 (100·00)	606 (100·00)	1630 (100·00)

N.B.—Figures in brackets are percentages.

3.15 It will be seen from the above table that in the case of scheduled castes, scheduled tribes and backward classes the percentage of adopters using terminal methods was considerably higher than that of those using non-terminal methods. This indicates that these social groups had in general a greater preference for non-terminal methods. On the other hand in the residual category of "others" the percentage of adopters using non-terminal methods was considerably higher than those using terminal methods indicating a comparative preference for the former type of methods. The extension efforts to cover more and more people under family planning could take note of the comparative preference for terminal/non-terminal method by people from different social groups.

3.16 *Educational Levels*—The distribution of the selected household respondents according to the level of their education, and, under each educational level according to adopters and non-adopters, is shown in table 3.11. It would be observed therefrom that of the total sample respondents, illiterate comprised 51.8 per cent, Primary/Middle pass 34.6 per cent, Matric/Higher Secondary 10.7 per cent, graduate and 'others' 2.9 per cent. Among the sample adopters and non-adopters taken separately the percentages of respondents belonging to different educational level groups were, by and large, the same as in the total sample. Thus, the level of formal education as such came out as having little or no influence on the adoption of family planning measures.

Table 3-11 : *Distribution of Selected Household Respondents by Educational Level and by Adopters and Non-Adopters*

Educational level	Total No. of respondents canvassed	Adopters	Non-Adopters
1	2	3	4
1. Illiterate . . . . .	845 (51·8)	528 (51·56)	317 (52·31)
2. Primary but below Middle . . . . .	349 (21·4)	212 (20·70)	137 (22·60)
3. Middle . . . . .	215 (13·2)	128 (12·50)	87 (14·35)
4. Matric/Higher Secondary . . . . .	175 (10·7)	125 (12·20)	50 (8·26)
5. Graduate . . . . .	22 (1·4)	16 (1·57)	6 (0·99)
6. Post-Graduate & others . . . . .	24 (1·5)	15 (1·47)	9 (1·49)
Total . . . . .	1630 (100·00)	1024 (100·00)	606 (100·00)

N.B.—Figures in brackets are percentages.

3.17 *Occupational Groups*—Of the total number of respondents canvassed 38.7 per cent were cultivators; 25.5 per cent labourers; 18.2 per cent were in service; 12.64 per cent were engaged in industry, trade or transport; 3.6 per cent were in independent professions and the remaining 2.10 per cent were from the residual or 'other' occupational groups. The distribution of adopters and non-adopters among these occupational groups is shown in table 3.12.

Table 3.12 : *Distribution of Adopters and Non-adopters by Occupational Groups*

Occupational groups	Adopters			Non-adopters	Total
	Terminal methods	Non-terminal methods	Total		
1	2	3	4	5	6
1. Cultivators . . . . .	209 (35.72)	174 (39.63)	383 (37.40)	248 (40.92)	631 (38.71)
2. Labourers . . . . .	167 (28.54)	75 (17.08)	242 (23.63)	173 (28.54)	415 (25.46)
3. Service . . . . .	104 (17.76)	113 (25.74)	217 (21.19)	80 (13.20)	297 (18.22)
4. Industry/Trade Transport . . . . .	74 (12.64)	53 (12.07)	127 (12.41)	68 (11.22)	195 (11.96)
5. Independent professions . . . . .	19 (3.24)	14 (3.18)	33 (3.22)	25 (4.12)	58 (3.55)
6. Others . . . . .	12 (2.10)	10 (2.30)	22 (2.15)	12 (2.00)	34 (2.10)
TOTAL . . . . .	585 (100.00)	439 (100.00)	1024 (100.00)	606 (100.00)	1630 (100.00)

N.B. : Figures in brackets are percentages.

3.18 Table 3.12 shows the distribution of the adopters in different occupational groups according to the use of terminal and non-terminal methods. It will be observed from this table that in two occupational groups, viz., cultivators and services, the percentage of adopters using non-terminal methods was distinctly higher than those using terminal methods. On the other hand, in the occupational category of labourers the percentage of sample adopters using terminal methods was appreciably higher than those using non-terminal methods. This suggests that in the propagation of family planning methods among these occupational groups their comparative preference for terminal and non-terminal methods should be taken into account.

3.19 *Income Groups*— The distribution of the selected sample households by their annual income levels is given in table 3.13. This shows that about two-thirds (65.5 per cent) of the sample households earned Rs. 6,000 or less per annum and about half of these (31.7 per cent of the total sample households) had an income of only Rs. 3,500 or less per annum.

Table 3.13 : *Distribution of Selected Households by Income Brackets*

Annual Income Level (Rs.)	No. & percentage of respondents
1	2
1. Upto Rs. 2,000 . . . . .	164 (10.1)
2. Rs. 2,001 to 3,500 . . . . .	352 (21.6)
3. Rs. 3,501 to 6,000 . . . . .	551 (33.8)
4. Rs. 6,001 to 10,000 . . . . .	854 (51.7)
5. Rs. 10,001 to 15,000 . . . . .	115 (7.1)
6. Rs. 15,001 & above . . . . .	94 (5.7)
Total . . . . .	1630 (100.0)

N.B.—Figures in brackets are percentages.

3.20 Table 3.14 shows the distribution of sample adopters and non-adopters by income levels. It would be seen therefrom that the percentage of adopters in different income brackets did not show any marked variations from the percentage of non-adopters in the corresponding income brackets. In other words, income levels had little or no determining influence on the adoption or otherwise of family planning measures. Adoption of family planning measures by eligible couples was due to factors other than that of income.

3.21 However, as between the sample adopters of terminal or non-terminal methods of family planning the income factor seemed to have some relevance. In the income brackets of Rs. six thousand and below, for instance, the proportion of sample adopters using terminal methods was comparatively higher than those practising non-terminal methods. On the other hand in the income brackets of above Rs. six thousand per annum the percentage of those using non-terminal methods was distinctly higher than those using terminal methods. In other words, whereas both types of family planning methods were practised by respondents in all the income groups, those in the income brackets of Rs. 6000 or less had a greater preference for terminal methods. On the other hand those in higher income brackets tended to prefer non-terminal methods. This suggests that for securing better results under family planning programme comparative preference for terminal and non-terminal methods in the lower and higher income brackets respectively should be duly taken into account.

Table 3-14 : *Distribution of Adopters and Non-Adopters by Annual Income Levels*

Income groups (Rs.)	Adopters			Non-adopters	Total
	Terminal methods	Non-terminal methods	Total		
1	2	3	4	5	6
1. Upto 2,000 . . . . .	71 (12.13)	26 (5.92)	97 (9.47)	67 (11.05)	164 (10.06)
2. 2,001 to 3,500 . . . . .	135 (23.07)	78 (17.76)	213 (20.81)	139 (22.94)	352 (21.60)
3. 3,501 to 6,000 . . . . .	211 (36.07)	141 (32.12)	352 (34.37)	199 (32.83)	551 (33.81)
4. 6,001 to 10,000 . . . . .	103 (17.60)	112 (25.52)	215 (20.99)	139 (22.94)	354 (21.72)
5. 10,001 to 15,000 . . . . .	37 (6.33)	42 (9.56)	79 (7.72)	36 (5.95)	115 (7.05)
6. 15,001 & above . . . . .	28 (4.80)	40 (9.12)	68 (6.64)	26 (4.29)	94 (5.76)
Total . . . . .	585 (100.00)	439 (100.00)	1024 (100.00)	606 (100.00)	1630 (100.00)

N. B.—Figures in brackets are percentages.



## Chapter 4

### EXTENSION METHODS AND MOTIVATION

Data on extension methods used and motivational efforts made by the extension staff under the family planning programme were gathered from 124 villages taken up for this study. These data were collected by interviewing household respondents and others, viz., VLWs (Village Level Workers), panchayat members, opinion leaders and knowledgeable people from selected villages. The data thus collected were further supplemented by the information culled out from relevant official records available at the level of PHCs, Sub-Centres, Panchayats, Blocks, etc. This chapter attempts an analysis of these data.

#### Extension Methods Used

4.02 During the years 1980-81, 1981-82 and 1982-83 (upto December 1982), the principal extension methods used to propagate family planning were film shows, group meetings, mass meetings, family planning camps, exhibitions, displays of posters and distribution of literature on the subject in the form of pamphlets. Table 4.1 gives the distribution of the selected villages according to the extension methods used to popularise family planning. It would be seen from this table that during the period under reference 78.2 to 82.3 per cent of the villages reported the distribution of pamphlets, 76.6 to 81.5 per cent holding of group meetings and 75.0 to 78.2 per cent displays of posters. The use of two important extension methods, viz., film shows and family planning camps, was, however, reported by only 16.1 to 32.3 per cent and 34.7 to 40.3 per cent of the villages, respectively,

Table 4-1 *Distribution of Villages by Extension Methods Used to Popularise Family Planning Programme*

Extension methods used	No. of villages reporting (N—124)		
	1980-81	1981-82	1982-83 (Upto December 1982)
1	2	3	4
1. Film shows . . . . .	35(28.2)	40(32.3)	20(16.1)
2. Group meetings . . . . .	95(76.6)	99(79.8)	101(81.5)
3. Mass meetings . . . . .	45(36.3)	51(41.1)	46(37.1)
4. Family planning camps . . . . .	47(37.9)	50(40.3)	43(34.7)
5. Exhibitions . . . . .	14(11.3)	16(12.9)	12(9.7)
6. Displays of posters . . . . .	97(78.2)	94(75.8)	93(75.0)
7. Distribution of pamphlets . . . . .	97(78.2)	98(79.0)	102(82.3)

N.B.— Figures in brackets are percentages.

4.03 With a view to assessing the extent of increase in extension efforts made, the distribution of villages by the use of main extension methods during the reference period of this study has been compared with that during the reference period of the earlier evaluation study on family planning undertaken by the PEO. This comparison is set forth in table 4.2. It would be seen from this table that the coverage of villages, under different extension methods to popularise family planning, increased significantly in 1982-83 as compared to in 1967-68. The proportion of villages covered under family planning camps for instance went up from 20.6 per cent in 1967-68 to 40.3 per cent in 1982-83. However, notwithstanding this increase, all villages in all the States should be covered under family planning camps at least every alternate year and film shows should be organised in each village at least twice a year especially around the time the crops have been sown and cultivators and labourers have more leisure hours on hand. It is around this time that the extension efforts under the family planning programme have to be extra vigorous in the countryside so as to be more effective and result oriented.

Table 4-2 : *Distribution of Villages by Main Extension Methods Used in 1967-68 and 1982-83*

Extension method used	Percentage of sample villages reporting popularisation through different extension methods during	
	1967-68	1982-83
1	2	3
1. Group meetings . . . . .	55.5	79.8
2. Mass meetings . . . . .	27.5	41.1
3. Film shows . . . . .	25.5	32.3
4. Family planning camps . . . . .	20.6	40.3

#### Frequency of Use of Extension Methods

4.04 The different extension methods used for educating eligible couples in family planning indicate the variety in the efforts made. Appendix table 4.1 gives the distribution of selected villages by the frequency of effort made in respect of different extension methods used. Some of the main findings emerging from the analysis of this data are briefly given in the subsequent paragraphs.

4.05 *Film Shows* : During the period under review film shows were organised five or more times in 5.0 to 5.7 per cent of the villages, three to four times in 5.0 to 12.5 per cent of villages, twice a year in 25.0 to 35.0 per cent of villages and once a year only in 55.0 to 57.5 per cent of villages. Thus, in the majority of the villages, film shows were organised once a year only.

4.06 *Group Meetings* : During the period under reference in 42.6 to 51.5 per cent of villages more than 12 meetings a year were organised. In another 20.2 to 24.7 per cent of villages group meetings were organised 7 to 12 times a year; in 18.8 to 21.2 per cent of villages 3 to 6 times a year; and in 7.1 to 13.9 per cent of villages upto 3 times a year.

4.07 *Mass Meetings* : In 52.9 to 56.5 per cent of the villages at least one mass meeting was organised each year; in 13.0 to 22.2 per cent of villages two, in 7.8 to 10.9 per cent of villages three to four, and in 15.6 to 19.6 per cent of villages five or more mass meetings were organised each year.

4.08 *Family Planning Camps* : Organising of family planning camps was perhaps the most widely used extension method. In as high as 70.0 to 72.0 per cent of the villages one or two camps were organised in a year. In 16.0 to 17.0 per cent of villages such camps were, in fact, organised five times or more in a year.

4.09 *Exhibitions* : Almost 100 per cent of the villages were covered under exhibitions relating to family planning once or more a year.

4.10 *Display of Posters and Distribution of Pamphlets* : Upto 12 posters a year were displayed in 44.3 to 100 per cent of villages during the period under reference and upto 25 pamphlets were distributed in 36.1 to 100 per cent of villages under study.

4.11 It will, thus, be observed that both the frequency of different extension methods used and the coverage of villages under them was generally quite high. However, excepting displaying of posters and distribution of publicity material the distribution of villages covered under other extension methods did not show any significant increase in 1982-83 (upto December, 1982) over 1980-81.

#### Attendance by Target Population

4.12 Appendix table 4.2 gives the distribution of selected villages by the average number of people who attended the meetings organised by officials and others concerned with the family planning programme. It would be seen therefrom that, during the period under reference, in 80.0 to 85.7 per cent of the villages more than 100 people attended each film show in a year. In 88.1 to 90.5 per cent of villages upto 50 people attended group meetings. In over 80.0 per cent of villages upto 50 people attended family planning camps. Likewise, in almost all villages family planning exhibitions were attended by 20 or more persons.

4.13 From the foregoing account, it will follow that in a large number of villages a sizeable number of people attended film shows, meetings, camps and exhibitions organised for propagating the family planning programme. This also indicates that from among the target group a significant number evinced interest in the programme.

#### **Contact of Sample Respondents with Mass Media**

4.14 In as much as the extent of the contact of the sample household with different mass media, such as radio, television and newspapers, could *inter alia*, indicate the relative potential importance of each medium in transmitting the message of family planning to rural population, information was collected on this aspect. Appendix table 4.3 gives the distribution of sample households according to the number of mass media (upto a maximum of three) they were in contact with/exposed to during the period under reference. Out of 1630 sample respondents, 1440 (88.3 per cent) were found to be in contact with one or the other mass media, i. e., radio, television and the newspaper. Of those who were in contact with mass media, 27.0 per cent were in contact with one, 33.5 per cent with two and 39.5 per cent three mass media. It was, however, observed that there was no appreciable difference in the percentage of adopters and non-adopters in contact with mass media. As against 84.3 per cent of the total sample respondents who were in contact with mass media in non-progressive districts, 92.4 per cent were in contact with mass media in progressive districts. But since as high as 88.3 per cent of total respondents were in contact with one or the other mass media and proportion of respondents in contact with mass media in progressive districts was appreciably higher as compared to non-progressive districts, it is obvious that mass media has a significant role to play in generating adequate degree of awareness among rural people for the adoption of family planning.

4.15 Appendix table 4.4 gives the distribution of the total number of sample respondents by types of mass media they were in touch with during the period under reference. Statewise data in this regard are presented in Appendix table 4.5. It would be seen from Appendix table 4.4 that the four major mass media, in the order of importance reckoned in terms of the number of respondents who reported contact with them, were: radio (81.7 per cent) cinema (44.3 per cent), newspapers (34.2 per cent) and hoardings/posters (34.1 per cent). Only 3.4 per cent of the sample respondents reported contact with television. This was probably due to the fact that in January/April 1983, when the field work for this study was undertaken, the television network had not spread over the length and breadth of the country and the facility of viewing television programmes could not have been available in many villages. Again, only 9.4 per cent of sample respondents reported contact with pamphlets and folders indicating that the use of pamphlets/folders as a mass media extension tool for propagation of family planning in rural areas has only a limited potential.

4.16 Of all the major mass media, radio emerged as the single most important medium. In States like Haryana, Kerala and Rajasthan almost all the sample respondents reported contact with this mass medium. This medium of mass contact should, therefore, continue to be extensively used to reach and educate the target groups of population in respect of the family planning programme and its related aspects. Besides, in view of the increase in television coverage within the country, this powerful audio-visual medium, along with the cinema, should be put to fuller and purposeful use for propagating family planning than what has been the case hitherto. Newspapers, and pamphlets/folders, etc., as a mass contact medium, it would seem, could be utilised more effectively in States/areas with a high level of literacy such as Kerala.

#### **Role of PHC Staff**

4.17 Five categories of officials, namely, Medical Officer, Lady Health Visitor, Block Extension Educator, Health Assistant/Family Welfare Health Assistant (FWHA) and Auxiliary Nurse Midwife (ANM), were canvassed to find out the frequency of their visits to the selected villages. Information collected on this aspect is given in Appendix table 4.6. Leaving aside the villages which were either the headquarters of a particular official and also those villages where the posts of the relevant officers were vacant during the period under reference, it was observed that Medical officers did not visit 24 to 27 of the selected villages, Lady Health visitor 22 to 24, Block Extension Educator 21 to 25, Health Assistant/FWHA 21 to 22 and ANM 11 to 13. It is not clear whether the villages not visited were common to different categories of the officials under reference. The first four categories of officials, thus, did not visit from 17 to 22 per cent of the selected villages and the ANM from 9 to 10 per cent of them. If the headquarter villages and villages in respect of which the relevant posts were vacant are not excluded for purposes of calculating the percentage of villages not visited, these percentages would be still higher. The family planning and related programmes in the villages not visited cannot be at par with the progress made in this respect in other villages. State Governments should, therefore, devise monitoring arrangements by which senior officers at different levels are apprised of the relevant details in this regard. In the case of villages difficult of access, the State departments concerned should make arrangements for transport/stay of officers in such areas.

4.18 It is further observed from Appendix table 4.6 that frequency of visits to different villages varied very widely, viz., from once a week to once a month. In the case of 30 to 52 per cent of villages it was once a month only. The frequency of visits, whatever it is, should be a pre-determined number and so arranged that during a week either one or the other medical personnel visits a village. This can be worked out and coordinated either at the PHC or the district level. Appendix table 4.7 gives State-wise data regarding frequency of visits by different categories of health officials.

### Role of Voluntary Agencies

4.19 Appendix table 4.8 gives data regarding the role of village and local leaders, school teachers, panchayats, *mahilla mandals*/yuvak mandals, and other voluntary organisations in the implementation of family planning programme in the selected villages. It would be observed from this that in 24 to 28 per cent of the villages local leaders and panchayats and in 40 per cent of villages school teachers had been assigned no role whatsoever. Further, there were no *mahilla mandals*/yuvak mandals in 73% of villages and no 'other voluntary organisations' in about 80% of these. There was, thus, little or no involvement of voluntary organisations and only a limited involvement of village and local leaders, panchayats and school teachers in the family planning programme. The involvement of village and local leaders, school teachers and panchayats, such as it was by and large was confined to motivational work, providing assistance in organising mass family planning campaigns/meetings, and in extension/health education only. As regards the extent of participation of these agencies in 40 to 56 per cent of the villages it was limited to motivational work, in 18 to 29 per cent of the villages to providing assistance in organising mass campaigns/meeting and in 15 to 18 per cent of the villages in helping in extension/health education.

4.20 Thus, the involvement of village and local leaders, school teachers, panchayats and voluntary organisations in the family planning programme, in terms of actual help and in terms of comprehensive coverage of the selected villages, was woefully inadequate. Since family planning programme has been envisaged as a voluntary programme, and since non-voluntary involvement in it is counter-productive, ways and means should be found to involve in much larger measure than hitherto, village and local leaders, panchayats, school teachers and voluntary organisations in family planning and connected activities in all villages.

4.21 Village, and local leaders, school teachers, panchayats and others were asked about the role assigned to them in furthering family planning programme. Appendix table 4.7 gives an idea of the role assigned to them in the selected villages. It would be seen from it that motivational work, offering assistance in organising mass campaigns/meetings and helping in extension/health education, were the three fields of activity in which the village leaders, etc., participated. Thus, in 55.2 to 78.8 per cent of villages, village and local leaders, school teachers, panchayats and *mahilla mandals*/yuvak mandals participated in motivational work; in 32.5 to 44.8 per cent of villages they participated in organising mass campaigns/meetings; and in 21.2 to 24.1 per cent of villages they participated in extension/health education. Their involvement in these three fields of activity should be channelised by planned efforts to this end.

## Chapter 5

### AWARENESS

Conceptually the process of adoption of family planning programme involves three stages, viz., (i) awareness of the programme and of the efficacy of different services and methods of family planning available and of the benefits expected from the adoption; (ii) acceptance of the programme at the conscious and emotional level; and (iii) the adoption of a suitable method or methods for spacing/limiting family size. This chapter deals with the first of these three stages. Relevant information on the subject was sought from all the 1024 adopters and 606 non-adopters selected for this study.

#### Awareness about Family Planning

5.02 It would be seen from table 5.1 that out of 606 non-adopters canvassed, 591 (97.5 per cent) said that they were aware of the family planning programme. In other words, almost all eligible couples were aware of family planning. Further, in the matter of awareness there was practically no variation as between progressive and non-progressive districts. Appendix table 5.1 gives the distribution of non-adopters according to awareness by selected districts/States.

Table 5.1—Distribution of Non-adopters According to Awareness About Family Planning Programme

Type of district	Aware	Not aware	Total No.
1. Progressive . . . . .	287 (97.6)	7 (2.4)	294 (100.0)
2. Non-progressive . . . . .	304 (97.4)	8 (2.6)	312 (100.0)
All districts . . . . .	591 (97.5)	15 (2.5)	606 (100.0)

N.B.—Figures in brackets are percentages.

#### Year of Contact

5.03 Table 5.2 gives the distribution of the selected adopters and non-adopters by year of their contact with the programme through audio, visual or personal media. It would be observed from this table that the adopters and non-adopters coming into contact during the first three years of the Sixth Five Year Plan, 1980-81 to 1982-83 comprised 12.3 and 15.2 per cent respectively of the total number selected for this study. The remaining 87.7 per cent and 84.8 per cent of the adopters and non-adopters respectively were those whose contact with the programme was in the period of six years or before the commencement of the Sixth Plan. This distribution, *inter alia* indicates that, other things being the same, the length of the period of contact, whether through audio, visual or personal media, was of little or no significance in the adoption of family planning. In other words, the number of eligible couples adopting family planning was not contingent upon the duration of their awareness.

Table 5.2—Distribution of Adopters and Non-adopters by Year of Contact With Family Planning Programme/Mass Media

Year of Contact	Adopters			Non-adopters		
	Progressive districts	Non-progressive districts	All-districts	Progressive districts	Non-progressive districts	All districts
1. Upto March 1974 . . . . .	61 (11.7)	31 (6.2)	92 (9.0)	53 (18.5)	36 (11.9)	89 (15.1)
2. April 74 to March 79 . . . . .	370 (70.7)	303 (60.5)	673 (65.7)	182 (63.4)	167 (54.9)	349 (59.0)
3. April 79 to March 80 . . . . .	56 (10.7)	77 (15.4)	133 (13.0)	27 (9.4)	36 (11.8)	63 (10.7)
4. April 80 to March 81 . . . . .	25 (4.8)	42 (8.4)	67 (6.5)	16 (5.6)	35 (11.5)	51 (8.6)
5. April 81 to March 82 . . . . .	11 (2.1)	48 (9.6)	59 (5.8)	6 (2.1)	18 (5.9)	24 (4.1)
6. April 82 to March 83 . . . . .	0 (0.0)	0 (0.0)	0 (0.0)	3 (1.0)	12 (3.9)	15 (2.5)
Total No. . . . .	523 (100.0)	501 (100.0)	1024 (100.0)	287 (100.0)*	304 (100.0)*	591 (100.0)*

N.B.—All figures in brackets are percentages.

\*Seven non-adopters from progressive and eight non-adopters from non-progressive districts are excluded as they reported no 'awareness'.

## First Source of Information

5.04 Table 5.3 attempts to bring out the position regarding source of information about family planning in respect of adopters as well as non-adopters. The family planning staff was the first source of information for the highest number of adopters (47.3 per cent) as well as non-adopters (73.4 per cent). The next important sources of first information were 'spouse' and 'relatives & friends' in the case of adopters (20.7 per cent) and 'motivators' (5.3 per cent) in the case of non-adopters. 'Spouse' and 'relatives and friends' together as first source of information, however, accounted for only 2.7 per cent of non-adopters. On the other hand, 'motivators' were the first source of information for only 2.0 per cent of adopters and it, thus, appeared that family planning staff and motivators, as the first source of information did not seem to have been as effective in the case of adopters as they were in the case of non-adopters. 'Spouse' and 'relatives and friends' and 'mass media', as the first source of information, seemed to have been quite effective in creating awareness about family planning among adopters. In the case of adopters, other adopters were comparatively more important as a first source of information than doctors and motivators taken together who were directly and officially concerned with the propagation of family planning. The other sources, such as meetings, camps and fairs, community leaders and block staff, did not play any significant role as a first source of information. In view of this, there is need for introspection as to the tangible role of these agencies as the first source of information. Greater reliance may, therefore, have to be placed on 'spouse', 'relatives and friends' and 'mass media', i.e., non-official channels, as a first source of information besides of course the family planning staff.

Table 5.3—Distribution of Adopters and Non-adopters by First Source of Information Regarding Family Planning Programme

Source of Information	Adopters			Non-adopters		
	Progressive districts (N=523)	Non-progressive districts (N=501)	All districts (N=1024)	Progressive districts (N=287)	Non-progressive districts (N=304)	All districts (N=591)
1	2	3	4	5	6	7
1. Family Planning Staff . . . . .	44.5	50.0	47.3	77.0	70.1	73.4
2. Relatives and friends . . . . .	15.4	12.8	14.1	2.1	2.6	2.4
3. Spouse . . . . .	4.6	8.8	6.6	0.4	0.3	0.3
4. Adopters . . . . .	9.0	4.2	6.6	5.2	3.3	4.2
5. Doctors . . . . .	3.3	3.4	3.3	2.8	6.3	4.6
6. Motivators . . . . .	2.1	1.8	2.0	4.5	5.9	5.3
7. Meetings/camps/fairs . . . . .	1.5	0.0	0.8	1.0	3.0	2.0
8. Community leaders . . . . .	0.6	0.4	0.5	0.7	0.3	0.5
9. Mass media . . . . .	11.5	6.8	9.2	2.1	4.9	3.6
10. Block staff . . . . .	0.6	2.6	1.6	0.0	0.0	0.0
11. Others . . . . .	6.8	9.2	8.0	4.2	3.3	3.7

N.B.—All figures are percentages.

## Subsequent Contacts

5.05 In order to find out whether *sustained* efforts were made by the concerned officials/agencies to persuade non-adopters to adopt family planning, the latter were asked whether anybody had contacted them subsequent to the first contact. Table 5.4 gives the distribution of the non-adopters according to the number reporting subsequent contacts by official agencies. It will be observed from this table that 72.4 per cent of the total non-adopters did report contact(s) subsequent to the first contact.

Table 5.4—Non-adopters Reporting Contacts Subsequent to the First Contact

Non-adopters	Progressive districts	Non-progressive districts	All districts
1. Reporting subsequent contact . . . . .	240(81.9)	197(63.3)	437(72.4)
2. Reporting no subsequent contact . . . . .	54(18.1)	115(36.7)	169(27.6)
Total No. . . . .	294(100.0)	312(100.0)	606(100.0)

N.B.—Figures in brackets are percentages.

5.06 Out of 437 non-adopters reporting subsequent contact(s) by official agencies, 36.8 per cent reported contact by only one category of a staff; 28.6 per cent by two; and 34.6 per cent by three (or more) categories of staff. Appendix table 5.2 gives the distribution of these non-adopters by the category of staff who contacted them. It would be observed therefrom that out of 437 non-adopters, who reported having been contacted subsequent to the first contact, 38.2 per cent reported having been contacted by auxiliary nurse-mid-wife, 30.9 per cent by other family planning staff, 21.3 per cent by motivators, 21.2 per cent by Village Health Guide, 18.3 per cent by Lady Health Visitor/Public Health Nurse, 15.6 per cent by 'adopters', 11.2 per cent by Extension Educators and the rest by others, such as friends, doctors, relatives, community leaders, block staff, etc. Those contacted by voluntary agencies comprised only 0.2 per cent of the total number of non-adopters. Voluntary agencies, thus, played practically no role whatsoever in propagating family planning.

#### Awareness of Family Planning Methods

5.07 Between 79 and 87 per cent of adopters as well as non-adopters said that they were aware of more than one family planning method. The position in this regard between progressive and non-progressive districts was found to be similar. This indicates that the dissemination of information about family planning was being directed to all people under the programme. This also shows that the non-adoption of family planning methods was not for want of knowledge about these on the part of non-adopters but because of other reasons.

5.08 With a view to ascertaining the level of knowledge as to different family planning methods, eligible couples were asked to name the different methods known to them. Appendix table 5.3 gives the distribution [of all sample adopters and non-adopters, for all the selected districts/States taken together, according to their knowledge of these methods.

5.09 It would be seen from Appendix table 5.3 that tubectomy was known to the largest number of the selected respondents, viz., 80.1 per cent of the adopters and 67.7 per cent of non-adopters. Vasectomy was known to between 52 and 53 per cent of adopters as well as non-adopters. However, the number of those knowing about the other major family planning methods was much higher in the case of adopters than among non-adopters. Thus, whereas 44.7 per cent of adopters knew about IUD/Copper-T, only 27.9 per cent of non-adopters knew of it. Similarly, whereas 40.3 per cent and 13.0 per cent of adopters knew of condoms and oral pills respectively, only 23.0 per cent and 3.0 per cent of non-adopters knew about these methods. As for other methods, viz., foam tablets, jelly/cream tubes, MTP. (Medical Termination of Pregnancy), rhythm (safe period method), withdrawal, abstinence, etc. only a fraction of both adopters and non-adopters knew about these methods. As regards the knowledge about terminal (viz., tubectomy and vasectomy) and non-terminal (viz. IUD/Copper-T condom, oral pills, foam tablets, cream and diaphragm etc.) methods, this was more in evidence in case of adopters than among the non-adopters. The percentage of adopters reporting knowledge of different family planning methods did not show any marked variation as between progressive and non-progressive districts. As for non-adopters the extent of their knowledge of different family planning methods was in general comparable to that of adopters in progressive as well as non-progressive districts.

5.10 It is evident from the foregoing account that the knowledge of different family planning methods among adopters as well non-adopters was mainly confined to terminal methods of tubectomy and vasectomy followed by the non-terminal methods of IUD/Copper-T and condoms, in that order of importance. This could be taken to reflect the relative degree of emphasis on these methods in the operation of the programme. It is surprising that the rhythm method was known to only 1.2 per cent of adopters and 0.2 per cent of non-adopters. Likewise, MTP was known to 0.4 per cent of adopters and 0.2 per cent of non-adopters. This points to a rather lop-sided approach in the matter of propagation of different family planning methods. The heavy and practically exclusive emphasis on terminal methods of tubectomy and vasectomy also sheds some light on a pertinent point as to why there is such

a large percentage of non-adopters despite the family Planning programme having been in operation for over three decades now. Obviously, if a large enough percentage of eligible couples did not want to 'terminate' their option to have children later on and were not well-informed regarding the other non-terminal methods available, especially like the MTP method, they remained non-adopters due to the sheer lack of knowledge as to the availability of methods which could be suitable and acceptable for them.

5.11 The above suggests that it should be the endeavour of the agencies/functionaries concerned with the family Planning programme to inform the eligible couples on all methods of family planning clearly differentiating between the 'terminal' and 'non-terminal' options available to them, instead of putting all out emphasis (in terms of persuasion and incentives) on terminal methods simply because these happen to be certain and irrevocable. If it is known to the eligible couples that there are methods of family planning which make the option of revocability available to them, this will go a long way in their over-coming hesitations and fears in respect of the adoption of family planning. In matters so personal and emotive as marital relations and begetting children, individual couples indeed desired full freedom of choice rather than to accept denial voluntarily or under the persuasive influence of incentives or media. And certainly a main plank of the efforts to spread knowledge of family Planning should be to clearly explain to all eligible couples that if and when a particular non-terminal method may fail and an unwanted pregnancy takes place the fool-proof MTP method would still be available. The knowledge regarding the availability of MTP method should induce a significant proportion of non-adopters to adopt at least non-terminal methods.

### **Awareness of Benefits Expected**

5.12 Appendix Table 5.4 presents the views of sample adopters and non-adopters on the benefits expected by them from the adoption of family planning. Both adopters and non-adopters listed multiple advantages. It is interesting to note that the number of non-adopters who listed different advantages/benefits of family planning compared favourable with that of adopters who listed the same advantages. For example, the reason 'large family difficult to provide for' was listed by 47.2 per cent of non-adopters as against 48.7 per cent of adopters. Reasons such as 'will help maintain/improve living standards' and 'easy to adopt' were listed by almost an equal percentage of non-adopters and adopters. This indicates that the non-adopters were almost as knowledgeable and convinced about the advantages of family planning as the adopters. Thus, so far as the generation of the awareness for the need for family planning is concerned, the family planning programme has done its part.

5.13 As regards the nature of expected benefits, it would be seen from Appendix table 5.4 that economic benefits, such as 'small family, happy family', 'better-care of children', 'large family difficult to provide for', 'maintain/improve living standards', were listed by the largest number of adopters as well as non-adopters. The incentives extended for adopting family planning measures were listed only by a bare 5.2 per cent of adopters and 5.8 per cent of non-adopters. It follows from this that those who went in for family planning did so for personal and economic reasons and the incentives provided under the programme were, by and large, an inconsequential factor in decision making. This suggests that essentially the rationale and emphasis of the family planning programme should be increasingly oriented towards the provision of adequate facilities and necessary supplies either free or at a nominal cost well within the reach of all sections of the population.

### **Reaction of Adopters to Benefits Expected**

5.14 The adopters were also asked about their general reaction in terms of 'favourable', 'unfavourable', or 'no reaction', as to the expected benefits from the adoption of family planning. About 80 per cent (79.9%) of the adopters reported that they had a favourable reaction, 10.1 per cent unfavourable but the remaining 10 per cent or so reported no reaction.

### **Reaction of Non-adopters to Benefits Expected**

5.15 Appendix table 5.5 gives the reaction of non-adopters to the message of benefits expected (as different from cash incentives) from the adoption of family planning. It would be observed from this appendix table that in the case of five types of benefits, viz., (i) 'large family difficult to maintain', (ii) 'small-family, happy family', (iii) 'will help in better care of health and education of children', (iv) 'in the interest of wife's health', and (v) 'will help to maintain/improve living standard', 58.1 to 68.8 per cent of the reporting adopters had expressed favourable view, 13.0 to 22.0 per cent unfavourable view, and 14.0 to 19.3 per cent had no reaction to offer. Since all these economic messages registered well in the minds of eligible couples, these could continue to be used.

### **Reaction of Non-adopters to the Message of Different Family Planning Methods**

5.16 The non-adopters were also asked to give their reaction (in terms of favourable, unfavourable and no reaction) to the message of different family planning methods. In the case of only four methods, viz., (i) tubectomy, (ii) vasectomy, (iii) IUD/Copper-T, and (iv) condom, 10 per cent or more of the non-adopters gave their reaction. It would be seen from Appendix table 5.6 that those favouring these methods ranged between 35.5 and 49.1 per



cent; those who did not favour ranged between 29.7 and 49.5 per cent; and those who had no reaction to offer ranged between 15.0 and 25.7 per cent. Thus, the views of non-adopters to the messages on the family planning methods were quite divided. Whereas IUD/Copper-T was favoured by 49.1 per cent, vasectomy was not favoured by 49.5 per cent of non-adopters (who had expressed their reaction in respect of these messages on family planning methods). On the whole, the non-adopters did not favour the terminal methods and, conversely, favoured the non-terminal methods. It again brings out the need to popularise non-terminal methods, as equally useful family planning methods, to control family size.



## Chapter 6

### ACCEPTANCE AND ADOPTION

Since the actual adoption of family planning does not come about simply due to awareness and there is an intermediate or transitional phase between awareness and adoption, the duration of this interval phase acquires relevance. As a part of the respondent schedule canvassed, the adopters were therefore asked as to whether there was any time-lag between awareness and acceptance, acceptance and adoption and awareness and adoption of family planning methods. They were also asked about the duration of the time-lags and related aspects, such as voluntariness of adoption, adopters as extension agents, and the role of incentives, assistance and other steps in popularising family planning. This chapter is devoted to an analysis of these aspects.

6.02 Out of 1024 adopters, 781 (76.3 per cent) reported time-lag between awareness and acceptance; 457 (44.6 per cent) between acceptance and adoption; and 930 (90.8 per cent) between awareness and adoption. Appendix table 6.1 gives the distribution of these adopters according to the time-lags involved. The time-lags involved between awareness and adoption varied from less than six months in the case of 5.8 per cent of the adopters to 96 months or even more in the case of 7.2 per cent of the adopters. Some 68.2 per cent of the sample adopters reported time-lags of 24 to less than 96 months. Only 24.7 per cent reported time-lags of less than 24 months. Thus, in the case of as high as 76.3 per cent of the adopters reporting time-lags, the time-lags involved between awareness and adoption varied as widely as two to eight years or more. This is indicative of a discouragingly long time-lag or the slow rate of adoption of family planning by the couples. With such a long time-lag the family planning programme obviously cannot make the desired impact on reducing the reproduction rate.

6.03 It has to be borne in mind that the time-lag of every one year or more means the probability of one more child per eligible couple. It, therefore, follows that the focus of the efforts under the programme has to be on reducing the time-lag between acceptance and adoption to the minimum. In fact, once an eligible couple has accepted the usefulness and the need for family planning, there should practically be no time-lag whatsoever thereafter between acceptance and adoption.

6.04 The time-lag between awareness and acceptance should also be reduced drastically. It is scarcely understandable that it should take as much as two to eight years for eligible couples already aware of the family planning programme to come to accept it and thereafter actually adopt family planning. This points to the need for evolving an effective and well thought-out strategy for the propagation of family planning whereby the time-lags are greatly reduced and eliminated. Such a strategy will have, apart from aiming to remove the factors responsible for the wide time-lags, also to concentrate on advocating family planning methods better suited and more acceptable to different target groups of the couple in the reproductive age groups.

#### Reasons for Time-lags

6.05 Appendix table 6.2 sets out an analysis of the different reasons given by the sample adopters reporting time-lag as between awareness and acceptance and between acceptance and adoption. The different reasons have been grouped into seven sets. It would be seen from this table that the reasons given in both the cases were intrinsically the same, viz., fears of after effects and/or of undergoing operation (in the case of terminal methods); desire for children—male, female or more; objection/discouragement from friends, relatives and spouse; medical/health grounds; etc. This leads to the conclusion that the two or three stages, namely, that of awareness, acceptance and adoption, through which a couple is presumed to pass before adopting family planning methods, were in effect one single phase and should, therefore, be treated as such. That is to say, the efforts should specifically be to reduce the time-lag between acceptance and adoption to a minimum. This is also desirable because longer the time-lag between acceptance and adoption, the lower would be the number of eligible couples adopting family planning methods per year, and therefore, the cost of persuading all the eligible couples to adopt family planning methods could also be correspondingly higher.

6.06 From out of the 10 reasons given by adopters for time-lag two, viz., 'fear of after-effects' and 'fear of undergoing operation' imply that the eligible couples were not fully convinced about the desirability of adopting family planning methods. A third reason, that is, 'not fully convinced' could be grouped under 'fears and misconceptions'. Likewise, the reasons of desire for male child, female child and/or more children can be grouped together under the head 'desire for children'. Also, 'objection from spouse' and 'discouragement by friends and relative'

can be combined under the head 'discouragement by friends, relatives and spouse'. This re-grouping would thus give seven broad sets of reasons for time-lags. In terms of this re-grouping of different reasons given it would follow from the analysis set forth in appendix table 6.2 that the most important reason for time-lag between awareness and acceptance as well as between acceptance and adoption, as given by 54.5 and 35.8 per cent of the respective respondent adopters, was 'fears and misconceptions'. 'Desire for more children' was the reason given for the time-lag between awareness and acceptance by 42.4 per cent of the respondent adopters and for time-lag between acceptance and adoption by 28.3 per cent of the respective respondent adopters followed by 'discouragement from friends, relatives and spouse' by 25.8 per cent of the respondents for time-lag between awareness and acceptance and by 29.1 per cent between acceptance and adoption. The fourth main reason, viz., 'medical and health grounds' was given by 17.4 per cent and 28.4 per cent of the respective respondents.

6.07 Since 'fears and misconceptions' was given as a reason by 54.5 per cent of the respondent adopters for time-lag between awareness and acceptance and by about 36 per cent of the respondents for the time-lag between acceptance and adoption, it is evident that the propagation of the family planning programme was not delivering the message of family planning as efficiently and as effectively as required. It is, therefore, important that ways and means should be found not only to fully and quickly convince the couples about the desirability and usefulness of adopting family planning but also to remove and dispel the fears and misconceptions several of them may have about family planning methods. For convincing couples and dispelling their fears, it is necessary that both husband and wife are approached and preferably together. Convincing one of the partners only should not be considered enough. For this purpose the strength of the female staff engaged in this work, at various levels and in different capacities, should be adequate.

#### Reasons for Non-Adoption

6.08 The analysis of the reasons for time-lags between awareness, acceptance and adoption given above will provide an idea of the causes of slow adoption of family planning by the sample adopter respondents. However, the sample non-adopters were also asked to give reasons for not adopting family planning. Appendix table 6.3 gives an analysis of the reasons stated by 606 sample non-adopters. It will be observed from this table that reasons associated with 'fears and misconceptions' accounted for as many as 61.1 per cent of the sample respondents not adopting family planning methods. This same factor 'fears and misconceptions', it will be noted, accounted for time-lag between awareness and acceptance among 54.5 per cent of the adopters and for 35.8 per cent of adopters for the time-lag between acceptance and adoption. 'Desire for more children' was stated as a reason by 44.3 per cent of non-adopters. This reason again was also the other reason mentioned by adopters for the time-lag between awareness, acceptance and adoption respectively. 'Objection' by spouse/'discouragement by relatives and friends' and 'cultural and religious, reasons were the other two main reasons for the non-adoption of family planning methods by the sample non-adopters. These were also the other important reasons for time-lags given by the adopters. The marked similarity between the reasons for non-adoption among non-adopters and for time-lags among adopters positively suggest that the same type and quality of effort is required both to make the adoption of family planning methods more effective among adopters and to secure their greater adoption among non-adopters. It would also be further observed from Appendix table 6.3 that some of the reasons given by non-adopters (as listed under different broad-heads) included such reasons as the family planning 'harmful to health' (19.5 per cent of non-adopters), 'no faith in family planning methods' (13.2 per cent), 'no knowledge of family planning methods' (2.8 per cent). This reflects that the extension efforts made by the staff employed under the family planning programme need to be considerably improved both as to their quality and content in order to remove misgivings and to impart correct knowledge about family planning.

#### Reasons for Adoption

6.09 Turning to the analysis of the reasons for the adoption of family planning, from among 1024 adopters canvassed, 49.6 per cent adopted family planning for mainly economic reasons, 17.4 per cent on health and medical grounds; 4.0 per cent because they found the recommended methods easy to adopt and reversible, if desired; and the remaining 29.1 per cent for other general reasons. (Appendix Table 6.4). Among the economic reasons given 'large family difficult to afford' and 'helps to take better care of children's health and education', were the predominant reasons. Similarly among general reasons 'small family happy family' came out as having the widest appeal. This suggests that it is a distinct stress on these advantages of family planning which would evoke the maximum response to the message of the family planning programme.

#### Whether Adopted Family Planning Voluntarily

6.10 All the selected adopters were asked as whether they felt that any direct or indirect coercion was used in making them adopt family planning. The replies given by them have been tabulated in table 6.1. While 97.4 per cent of the respondents said they had adopted family planning voluntarily, 2.6 per cent said

that it was not voluntary on their part. The proportion of such respondents was 1.2 per cent for the progressive districts but 4.2 per cent for the non-progressive districts. Even though the percentage of those who felt that they were made to adopt family planning non-voluntarily was insignificant, in the wider interests of the programme it would seem highly desirable that the methods and techniques of propagation do not at all detract from the voluntariness of the programme.

Table 6.1: *Distribution of Adopters by the Voluntariness of Adoption.*

How adopted	Progressive districts	Non-progressive districts	All districts
1	2	3	4
1. Voluntarily . . . . .	517 (98.8)	480 (95.8)	999 (97.4)
2. Not voluntarily . . . . .	6 (1.2)	21 (4.2)	27(2.6)
<b>Total</b> . . . . .	<b>523 (100.0)</b>	<b>501 (100.0)</b>	<b>1024(100.0)</b>

N.B.—Figures in brackets are percentages.

#### Adopters as Extension Agents

6.11 Table 6.2 summarises the information collected as regard the number of sample adopters who had advised non-adopters to adopt family planning and the number of non-adopters who began to practise family planning as a result of such advice from adopters. Out of 1024 selected adopters, 529 or 51.7 per cent had occasion to talk about family planning (methods) with non-adopters and advise them to follow it. On an average an adopter had talked on the subject of adoption with 5.4 persons and about eighty per cent (4.3 persons) of these had followed the advice given. This indicates not only a very high multiplier effect but also this that the adopters were and can play the role of good, voluntary extension agents of the family planning programme. In as much the advice of those who have actually adopted family planning and their experience of the methods used can be much more convincing than only guidance and education, ways and means should be devised to make effective use of adopters to the maximum extent to propagate family planning among non-adopters and thereby enhance the impact of the programme. Apart from the efforts in various other directions, a scheme could be devised whereby adopters could be engaged and retained at a reasonable fee, or by giving some other suitable incentive, to work as motivators.

Table 6.2: *Adopters Reporting Advice to Non-Adopters Regarding Family Planning.*

Adopters reporting	Progressive districts (N=523)	Non-progressive districts (N=501)	All districts (N=1024)
1	2	3	4
1. Having advised others . . . . .	298 (57.0)	231 (46.1)	529 (51.7)
2. Having not advised others . . . . .	225 (43.0)	270 (53.9)	495 (48.3)
3. Persons advised			
(i) Total number . . . . .	1647	1202	2849
(ii) Average number per adopter . . . . .	5.5	5.2	5.4
4. Total no. of persons followed advice . . . . .	866	1398	2264
5. Average number of persons who followed advice . . . . .	2.9	6.1	4.3

N.B.—Figures in brackets are percentages.

### Role of Incentives and Assistance in Propagating Family Planning

6.12 Incentives in cash and in kind (in the form of drugs, dressings, diet, etc.) and other incentives, like free transport, were the instruments found to have been devised and used by Government for the popularisation of the family planning programme. For the poor, these incentives were in the form of compensation for the wages lost by them for absence from work/duty for undergoing vasectomy/tubectomy and for meeting expenses incurred for hospitalisation and transport. Based on the information gathered from the sample adopters, table 6.3 attempts to bring out the extent to which the sample adopters were found to have received incentives in cash/kind. It would be seen from the table that as many as 63.8 per cent of the total sample adopters had received cash/kind incentives for adopting family planning methods (which in a large percentage of cases meant undergoing vasectomy/tubectomy). About 56 per cent of the total sample adopters got cash incentives and 7.9 per cent in both cash and kind. The percentage of adopters having received incentives in kind alone was insignificant.

Table 6.3: *Adopters Reporting Receipt of Incentives for Adopting Family Planning.*

Adopters reporting	Progressive districts	Non-Progressive districts	All districts
1	2	3	4
1. Receipt of Incentive			
(i) In cash . . . . .	287 (54.9)	282 (56.3)	569(55.6)
(ii) In kind . . . . .	3 (0.6)	(0.0)	3(0.3)
(iii) In both cash and kind. . . . .	37 (7.1)	44 (8.8)	81(7.9)
(iv) Total Number . . . . .	327 (62.5)	326 (65.1)	653(63.8)
2. Non-receipt of any incentive . . . . .	196 (37.5)	175 (34.9)	371(36.2)
Total No. of adopters. . . . .	523 (100.0)	501 (100.0)	1024(100.0)

N.B.—Figures in brackets are percentages.

6.13 Table 6.4 gives the distribution of selected adopters according to the amount of the incentives given and also indicates the average quantum of incentive in both cash and kind for the adopters who had received such incentives. For calculating the value of the incentives received in kind the value was imputed in the light of the information given by the concerned sample respondents. It will be seen from table 6.4 that of the adopters who got cash incentives, 54.4 per cent got a cash incentives of less than Rs. 105 each and 18.5 per cent got a cash incentive of Rs. 81 or less less. About 34 per cent got an incentive of between Rs. 106—150. Those who got a cash incentive of Rs. 150 or more comprised 11.8 per cent. Taking all the adopters who received cash incentive together, the average cash incentive comes to Rs. 127.20 per adopter. Only three respondents reported having received the incentive in kind only. (See table 6.4). However, these three respondents have been excluded from the figure given in table 6.4 as the imputed money value of the kind incentive received by them was formed to be neither significant nor plausible. For those who received both cash and kind incentives, the average quantum worked out to Rs. 260.40 per person.

Table 6.4 — *Distribution of Adopters According to Amounts of Incentives Received*

Incentive received	Progressive districts	Non-progressive districts	All districts
1	2	3	4
1. Cash incentive only			
(i) Rs. 1 to 80 . . . . .	54 (18.8)	51 (18.1)	105(18.5)
(ii) Rs. 81 to 105 . . . . .	100 (34.8)	104 (36.9)	204(35.9)
(iii) Rs. 106 to 150 . . . . .	81 (28.2)	112 (39.7)	193(33.9)
(iv) Rs. 151 & above . . . . .	52 (18.1)	15 (5.3)	67(11.8)
(v) Average Amount per person (Rs.) . . . . .	114.50	140.20	127.20
2. Both cash and kind incentive per person (Rs.) . . . . .	239.60	278.00	260.40

N.B.—Figures in brackets are percentages.

6.14 The 653 adopters who had received incentives were asked if they were satisfied with the incentives offered to them. Only about one-third said they were; another about one-third of them said they were not; and the rest expressed no view. The sample adopters were, in turn, asked to give their suggestions for improving the incentives. Only 318 respondents gave their suggestions. As most of these respondents gave multiple replies, the suggestion given by them added up to very much more than the total number of such respondents. Table 6.5 sets out the suggestions made by the adopters according to the relative importance of the suggestions made by them. It would be seen, therefrom, that 89.0 per cent of the suggestions were that the incentive amount should be more. A little over 42 per cent of the suggestions were for giving preferential medical treatment and 21.7 per cent for full compensation for loss of wages. While 12.9 per cent of the suggestions were that free transport and free accommodation should be provided in a PHC/hospital, 4.4 per cent were for according priority for agricultural loans/supplies of agricultural inputs, etc; and 1.3 per cent of the suggestions made were for longer special leave.

Table 6.5—*Suggestions Offered by Respondents Adopters Regarding the Type and Quantum of Incentives*

Suggestions offered	Percentage of adopters reporting (N=318)
1	2
1. Greater cash incentives to be given. . . . .	283(89.0)
2. Preferential medical treatment . . . . .	134(42.1)
3. Full compensation for the loss of wages . . . . .	69(21.7)
4. Free transport and free accommodation in PHC/hospital. . . . .	41(12.9)
5. Priority for agricultural loans/supplies of agricultural inputs . . . . .	14(4.4)
6. Longer special leave. . . . .	4(1.3)

N.B.—1. Figures in brackets are percentages.

2. Respondents gave multiple replies.

6.15 It is difficult to say whether the adopters who got cash/kind incentives came for vasectomy/tubectomy/insertion of IUD because of the incentive offered or that they availed of the incentive simply because it was available and would have gone in for family planning irrespective of the availability of the cash/kind incentives. However, assuming that the sample adopters were of both types, i.e. those who were induced by the incentive offered and also those who availed of the incentive as these were available, the role of the incentives as an inducement does not come out clearly. It may, however, be noted in this context that the Ministry of Health and Family Welfare reportedly revised the pattern of Central Assistance for payment of compensation (incentives) from March 1983 raising it from Rs. 170 to Rs. 200 in the case of tubectomy; from Rs. 150 to Rs. 180 in the case of vasectomy; and from Rs. 8 to 12 in case of IUD. If the rationale behind the provision of compensation is only removing the hinderance of transitory factors like loss of wages, and costs involved in travel, enforced absence from work, etc., which could come in the way of the adoption of a suitable family planning method, then the quantum of incentive/compensation given should be more closely related to these aspects. On the other hand, if the purpose is also to provide an inducement for going in for family planning then the incentive should be reasonably attractive. Incentives to be effective have to be not marginal and niggardly but substantial and alluring. The incentive amount offered for vasectomy/tubectomy could for instance, be a sum of money equivalent to about 3 to 4 months wages and for the insertion of IUD 2 to 3 weeks wages of a daily labourer. In case of IUD-also it would be one time incentive only. In case of daily wage/casual workers, they should be given full compensation for the loss of wages as well as other direct and indirect costs incurred by them in addition to the prescribed incentive money for vasectomy/tubectomy/insertion of IUD. For the other classes of employees, in whose case money incentive or the costs entailed are not a very material consideration, concession such as a longer period of leave should be considered. This also leads to the point that if the choice of a particular method is to be left to the individual adopters, a differential in the prescribed rates of incentives for adopting particular non-terminal methods is scarcely understandable. Instead, the accent should be on provision of more adequate facilities for those who find these methods more suitable or need them. For example, in areas where industrial/agricultural labourers are in a majority special family planning clinics should be opened with adequate facilities for vasectomy, tubectomy, post-operation care, follow-up measures, etc.

6.16 A further point for consideration is that the quantum of compensation/incentive for those going in for vasectomy, tubectomy and IUD insertions should not be the same for all categories of the adopters of these devices and should instead be related in a suitable manner to the stage at which these methods are adopted. If the provision of the incentive is necessary, the amount of the incentive should be considerably higher if these methods are adopted after the birth of the first child, less after the second child and the lowest after the third child. The case for evolving such a graded system of incentives rests on the ground that it is the early adoption of the effective family planning method which deserves to be compensated for rather than its adoption at a late stage when a couple has already got two or three children. That is to say, the distinct emphasis of any system of incentives should be on restricting the number of children and population growth and not merely an adoption of a terminal method at any stage.

*Views of the Sample Respondents, Their Suggestions, etc.*

6.17 With a view to eliciting the general opinion of the sample respondents as to the operation of the family programme since 1980, as part of the questionnaire canvassed they were asked to indicate their general views [in terms of (i) adequate/satisfactory, (ii) not adequate/not satisfactory, (iii) deteriorated and (iv) cannot say] in respect of such aspects of the family planning programme as (a) availability of the family planning programme at the village level, (b) frequency of contact/visit by family planning staff with the village people, (c) follow up after adoption, (d) timely availability of supplies/services, and (e) quality and quantity of family planning devices/medicines. They were also asked to give their suggestions for affecting improvements in regard to these aspects.

6.18 Table 6.6 sets out an analysis of the views expressed by the selected adopters in regard to the working of the family planning programme with reference to the aspects mentioned in the preceding paragraph. It will be observed from this table that a majority of the respondents, ranging between 56.3 and 64.3 per cent, expressed the view that the working of the relevant aspects of the programme was satisfactory/adequate. However, some 30 per cent of the respondents considered that the availability of the family planning staff at the village level, frequency of contact/visit by family planning staff and follow-up after adoption were not adequate or satisfactory. About 28 per cent of the adopters were also of the view that the timely availability of supplies was not satisfactory; 22 per cent considered that the quantity of family planning devices/medicines was not adequate and 15.7 per cent expressed the opinion that the quality was not satisfactory. Only a very small percentage of the sample respondents thought that the operation of the family programme *vis-a-vis* the relevant aspects had deteriorated since 1980.

Table 6.6 : *Views of the Selected Adopters on Selected Aspects of the Working of the Family Planning Programme*

Aspects	Adequate/ Satisfactory	Not Adequate/ Not satis- factory	Deteriorated	Cannot say
1. Availability of Family Planning Staff at the village level	658 (64.3)	303 (29.6)	22 (2.1)	41 (4.00)
2. Frequency of contact/visit by family planning staff	637 (62.2)	307 (30.0)	33 (3.2)	47 (4.6)
3. Follow-up after adoption	599 (58.5)	309 (30.2)	29 (2.8)	87 (8.5)
4. Supplies/services timely availability	615 (60.1)	284 (27.7)	25 (2.4)	100 (9.8)
5. Family Planning services/Medicines				
(i) Quality	599 (58.5)	161 (15.7)	14 (1.4)	250 (24.4)
(ii) Quantity	577 (56.3)	225 (22.0)	20 (2.0)	202 (19.7)

N.B.—Figures in brackets are percentages.

*Suggestions of the Adopters for Further Improvement in the Operation of the Programme*

6.19 As part of the structured schedule canvassed the sample adopters were also asked to give one or two suggestions for making further improvement in the working of the family planning programme in respect of the aspects discussed above. Table 6.7 indicates the number of sample adopters who offered one or two suggestions regarding each of the relevant aspects. As the sample adopters were free to offer suggestions in respect of one or more aspects the total number of adopters as shown in this table adds up to very much more than the total sample of 1024 adopters and also varies as between the different aspects.

Table 6.7 : Sample Adopters Offering Suggestions for Improvement Regarding Specific Aspects of Family Planning Programme

Aspects	No. of sample adopters offering suggestions	No. of sample adopters offering one/two suggestions		Total
		One suggestion	Two suggestions	
1	2	3	4	5
1. Availability of family planning staff at village level . . . . .	451	382 (84.7)	69 (15.3)	520
2. Frequency of contact with/visit of family planning officials to village people . . . . .	461	410 (88.9)	51 (11.1)	512
3. Timely availability of supplies/services . . . . .	385	351 (91.2)	34 (8.2)	419
4. Quality of family planning devices/medicines . . . . .	271	268 (98.9)	3 (1.1)	274
5. Quantity of family planning devices/medicines . . . . .	314	306 (97.5)	8 (2.5)	322
6. Follow-up by family planning staff after adoption . . . . .	534	497 (93.1)	37 (6.9)	571
7. Others . . . . .	61	61 (100.0)	0 (0.0)	61

N.B.—Figures in brackets are percentages.

6.20 The analysis of the suggestions offered by the sample respondents is attempted in Appendix table 6.5. The more important of the suggestions made by the adopters (the importance being reckoned on the basis of the number of adopters making a particular suggestion) are discussed in the succeeding paragraphs.

6.21 As regards the availability of the family planning staff at the village level, out of 451 adopters who gave suggestions on this aspect 359, or 79.6 per cent, said that either the area of jurisdiction of the family planning staff should be reduced or the number of the staff should be increased. Another 63, or 14 per cent, said that either the staff should be provided accommodation at their place of posting or they should be given free transport facilities so that they can adequately cover the area under their jurisdiction. Some 9.8 per cent of the respondents also suggested more frequent domiciliary visits by the staff.

6.22 In respect of frequency of contact of villages/visit to villages by the family planning staff, out of 461 adopters who gave suggestions on this aspect, 79.2 per cent said that the family planning staff should do more frequent domiciliary visits; 12.4 per cent said that in order to enable them to do this, they should either be provided facility of accommodation at their place of posting or given free transport facility for the purpose; and 6.1 per cent said that either their area of jurisdiction should be reduced or more staff should be posted for the purpose. About 2.8 per cent of the sample respondents suggested more publicity for the programme; 2.2 per cent suggested more audio-visual aids for the field staff; and 2.0 per cent for increased incentives to the staff engaged in the programme.

6.23 Of the adopters who gave their suggestions on the aspect relating to timely availability of the supplies, 58.2 per cent said that the supplies of contraceptives and medicines should be regular and adequate; 27.0 per cent said that prompt treatment should be made available to adopters in cases of complaint; 9.6 per cent suggested the opening of more distribution outlets for the supply of contraceptives; 2.8 per cent recommended more frequent domiciliary visits by the family planning staff; and 2.1 per cent (in each case) (a) the reduction in the jurisdiction of the staff or increase in their number and (b) ensuring of better quality of contraceptives.

6.24 Out of 271 adopters, who gave their suggestions in regard to the quality of family planning devices/medicines, as high as 98.5 per cent said that the quality of contraceptives should be better. Another 2.6 per cent gave miscellaneous suggestions.

6.25 As regards the aspect pertaining to quantity of contraceptives/medicines made available, 81.5 per cent of the responding adopters said that the supplies of contraceptives/medicines should be regular and adequate; 15.3 per cent suggested an increase in the number of distribution outlets for contraceptives; and 5.4 per cent gave miscellaneous suggestions.

6.26 In respect of the follow-up measures, out of 534 adopters who gave suggestions on this aspect 89.3 per cent suggested better follow-up of cases; 12.9 per cent said that in cases of complaint, prompt treatment should be made available; 1.1 per cent suggested more domiciliary visits and 3.6 per cent gave miscellaneous suggestions.



6.27 From the foregoing examination of the various suggestions offered by the sample adopters on the working of the six selected aspects of the family planning programme the following five suggestions came out as the more prominent one as these were made by a significant majority (79.2 per cent and above) of the adopters in each case :—

(i) ensuring regular and adequate supplies of contraceptives/medicines ; (ii) ensuring better quality of contraceptives/medicines ; (iii) better follow-up of all adopters ; (iv) more frequent domiciliary visits by the family planning staff ; and (v) either a reduction in the area of jurisdiction of the family planning staff or an increase in the number of family planning staff.

6.28 Apart from the above mentioned five suggestions, 14 per cent or more of the adopters also suggested :

- (i) opening of more distribution outlets for contraceptives ; and
- (ii) that family planning staff be provided either the facility of accommodation at their place of posting or supply of free transport facility to enable them to adequately cover the area in their jurisdiction.

6.29 In the light of the suggestions made by the sample respondents the following steps are recommended.

6.30 In order to ensure that there is no shortage of supplies of contraceptives in any of the family planning units, PHC, etc., it should be made obligatory on the part of these units, etc., to maintain at all times a stock of one month's requirements in advance.

6.31 While all efforts should be made to improve the quality of contraceptives, every reported case of the defective quality of contraceptives should be got fully investigated at a responsible level both with a view to institute remedial action and punitive action, where necessary, to minimise further quality defects in contraceptive devices.

6.32 The follow-up facilities should be suitably strengthened so that these are adequate and regularly available. A *modus operandi* should be evolved whereby prompt treatment is given in cases of complaint and thereafter regularly follow-up is done. To this end, all cases of vasectomy, tubectomy and of IUD should be regularly reviewed at stipulated intervals on a continuous basis. The follow-up action taken should be entered in the file register of each case. The spacing of this follow-up could be gradually increased with the passage of time if there are satisfactory results and an absence of complaints, or shortened if complications arise and the frequency of complaints increase. The file-register should be closed only when there is no post-vasectomy/tubectomy/IUD intertention complaint for a stipulated period of time.

6.33 While to an extent the desired frequency of contact of the family planning staff with the villages and more frequent domiciliary visits by them may be possible by careful harnessing of the available resources and by exercising proper checks and inspection to ensure that the stipulated number of visits to villages, etc., are, in fact, made by the concerned staff where necessary, the number of villages per PHC/sub-centre may be suitably reduced so that family planning facilities, even for terminal methods become available to all villages within bullock-cart distances.

6.34 It should also be the endeavour of the authorities responsible for the implementation of the programme to provide to its field staff residential accommodation at the place of their posting and also free transport facility for undertaking visits to villages under their jurisdiction. At the same time, it may be made compulsory for the field staff to reside at the place of posting. In cases where it is not found feasible to provide residential accommodation a suitable hardship allowance may be given to the concerned field staff.

## Chapter 7

### METHODS PRACTISED AND SUGGESTED

Adopters preferred different methods. In the light of the information gathered this chapter attempts to bring out the *raison d'être* of this preference, the extent of satisfaction and reasons for dissatisfaction with the methods practised. It also gives an idea of the methods suggested by adopters to non-adopters for adoption and attempts to identify the age-group which should be the prime target of the family planning programme.

#### Methods Practised

7.02 Adopters practised terminal as well as non-terminal group of methods. Table 7.1 shows the distribution of sample adopters according to the family planning methods practised. It will be observed therefrom that terminal methods of tubectomy and vasectomy were practised by 57.2 per cent of sample adopters and non-terminal methods, i.e., of condoms, IUD/Copper-T and oral pills, were practised by about 42.8 per cent of adopters. Of the five main family planning methods practised vasectomy and condoms were practised by men and tubectomy, IUD/Copper-T and oral pills by women. As would be seen from Table 7.1, tubectomy was practised by the largest percentage of adopters (47.2) followed by condoms (25.2 per cent), IUD/Copper-T (14.5 per cent), vasectomy (10.0 per cent) and oral pills (3.1 per cent). Out of a total sample of 664 women adopters, 483 (72.7 per cent) practised tubectomy. Out of a total of 360 male adopters canvassed, 258 (71.7 per cent) practised the condom method and only 102 (28.3 per cent) the vasectomy method. Thus, as between terminal and non-terminal methods, the former type of methods were preferred by the majority (57.2 per cent) of the sample adopters.

Table 7.1—Distribution of Adopters by Family Planning Methods Practised.

Methods Practised	Progressive districts	Non-progressive districts	All districts
1	2	3	4
1. Vasectomy . . . . .	61 (11.7)	41 (8.2)	102 (10.2)
2. Tubectomy . . . . .	230 (44.0)	253 (50.5)	483 (47.2)
3. IUD/Copper-T . . . . .	75 (14.3)	73 (14.6)	148 (14.5)
4. Condom . . . . .	134 (25.6)	124 (24.7)	258 (25.2)
5. Oral pills . . . . .	23 (4.4)	10 (2.0)	33 (3.1)
6. Total No. of adopters			
(i) Male . . . . .	195	165	360
(ii) Female . . . . .	328	336	664
(iii) Total . . . . .	523 (100.0)	501 (100.0)	1024 (100.0)

N.B.—Figures in brackets are percentages.

#### Year of Beginning of Practice of Family Planning

7.03 Table 7.2 gives the distribution of sample adopters by the year of adoption of family planning methods by them. It would be seen from this that all of the few sample adopters who used family planning methods from before 1974, used non-terminal methods of condom (66.7 per cent) and IUD/Copper-T (33.3 per cent). Of the sample adopters who began using family planning methods during 1974–80, 72.9 per cent used non-terminal methods and the remaining (27.1 per cent) terminal methods. The proportion of adopters of terminal methods went up from 27.1 per cent for the period 1974–80 to 56.2 per cent in 1980–81 to 66.2 per cent in 1981–82 and was 58.5 per cent for the first nine months of 1982–83 (i.e. upto

December, 1982). The rather sharp rise in the proportion of those using terminal methods among the selected adopters was mainly on account of a greater adoption of tubectomy and a corresponding decline in the proportion of those using condom method. *Prima facie*, this could be indicative of the adoption of terminal methods by couples after having the desired number of children. However, the rise in the proportion of adopters of tubectomy as a terminal method of family planning and vasectomy as a terminal method being much less preferred shows that either women were more family planning minded, or that the sacrifice involved was on the part of the female partners.

Table 7.2—Distribution of Adopters According to the Year of Adoption of Family Planning Methods

Method Adopted	Year of Adoption					Total
	Before 1974	1974—80	1980-81	1981-82	1982-83 (Upto-Dec., 82)	
1	2	3	4	5	6	7
<b>1. Terminal Methods</b>						
(i) Tubectomy . . . . .	0(0.0)	17(17.7)	138(46.6)	173(50.9)	162(53.8)	483 (47.2)
(ii) Vasectomy . . . . .	0(0.0)	9(9.4)	27(9.6)	52(15.3)	14(4.7)	102 (10.0)
Sub-Total . . . . .	0(0.0)	26(27.1)	158(56.2)	225(66.2)	176(58.5)	585 (57.1)
<b>2. Non-Terminal Methods</b>						
(i) Condom . . . . .	4(66.7)	53(55.2)	83(29.5)	65(19.1)	53(17.6)	258 (25.2)
(ii) IUD/Copper-T . . . . .	2(33.3)	15(15.6)	33(11.7)	44(12.9)	54(17.9)	148 (14.4)
(iii) Oral pills . . . . .	0(0.0)	2(2.1)	7(2.5)	6(1.8)	18(6.0)	33(3.2)
Sub-Total . . . . .	6(100.0)	70(72.9)	123(43.8)	115(33.8)	125(41.5)	439(42.9)
Total No. of adopters . . . . .	6(100.0)	96(100.0)	281(100.0)	340(100.0)	301(100.0)	1024 (100.0)

#### Reasons for Preference

7.04 Each adopter was asked to give the reasons for preferring a particular family planning method he/she was practising. Appendix table 7.1 gives the distribution of adopters by the methods practised and also presents an analysis of the reasons given by them for preferring the methods used by them. Among those who used oral pills and condom, 87.9 and 83.8 per cent respectively, gave comfort and convenience of using these methods as the reasons. IUD/Copper-T, condom and oral pills were also preferred by 56.1, 49.3 and 48.5 per cent of the adopters because these methods were good for spacing and were reversible. Vasectomy and tubectomy were preferred by 45.1 and 48.5 per cent of the respondents respectively as they considered these better and more reliable for preventing pregnancy. About 70 and 49 per cent gave comfort and convenience of use as the reasons for preferring these two respective methods. Forty six per cent of the sample adopters gave this reason for preferring IUD/Copper-T. Advice by spouse, relatives and friends as well as health staff was the reason given by 29.4 per cent of the sample adopters for vasectomy, 46.9 per cent for tubectomy, by 30.4 per cent for IUD/Copper-T, 13.7 per cent for condom and 18.1 per cent for oral pills. Reliability and comfort and convenience of use thus emerged in general as the major reasons for preferring different methods. On the other hand, money incentives came out as reasons of no consequence.

7.05 The reasons given by the sample respondents for preferring different family planning methods provide an idea of the strong points in favour of particular methods which could be kept in view in promoting their popularity. Thus, condom and oral pill, as methods of family planning, would sell best for reasons of comfort and convenience of use followed by being good for spacing and being reversible. Vasectomy and tubectomy would have greater appeal for "comfort and convenience of use" followed by being 'better and reliable'. IUD/Copper-T's strongest point for popularisation would seem to be its being good for spacing and reversible followed by 'comfort and convenience of use'.

#### *Extent of Satisfaction*

7.06 Table 7.3 gives the distribution of the sample adopters according to the extent of satisfaction with the methods used by them. It would be seen from this table that the number of those satisfied with the method adopted by them ranged between 81.0 and 87.3 per cent; the highest percentage of satisfied adopters being in the case of those who had adopted vasectomy. The percentage of 'not satisfied' was comparatively significant only in respect of those using IUD/Copper-T, condom and oral pills—9.5, 8.1 and 9.1 per cent respectively. About 9.1 per cent of the adopters, however, said that they were partially satisfied and 6.5 per cent said that they were not satisfied.

Table 7.3—Distribution of Adopters by Extent of Satisfaction with the Methods Adopted

Method used	Satisfied	Partially satisfied	Not satisfied	Total
1. Vasectomy . . . . .	89(87.3)	9(8.8)	4(3.9)	102(100.0)
2. Tubectomy . . . . .	411(85.1)	47(9.7)	25(5.2)	483(100.0)
3. IUD/Copper-T . . . . .	127(85.8)	7(4.7)	14(9.5)	148(100.0)
4. Condom . . . . .	209(81.0)	28(10.9)	21(8.1)	258(100.0)
5. Oral Pills . . . . .	27(81.8)	3(9.1)	3(9.1)	33(100.0)
Total No. of adopters . . . . .	863(84.3)	94(9.1)	67(6.5)	1024(100.0)

N.B.—Figures in brackets are percentages.

#### *Reasons for Dissatisfaction*

7.07 The 161 sample adopters who said that they were partially satisfied or dissatisfied with the family planning methods used by them were asked to give the reasons for their dissatisfaction. Appendix table 7.2 presents an analysis of the information collected on this aspect. It would be seen from this table that out of 161 dissatisfied adopters, 72 (44.7 per cent) use tubectomy, 49 (30.4 per cent) condom, 21 (13.0 per cent) IUD/Copper-T, 13 (8.1 per cent) vasectomy, and 6 (3.7 per cent) oral pills. The reasons given for dissatisfaction indicated that this was, broadly speaking on three major counts, viz., (i) physical discomfort; (ii) less pleasure giving, and (iii) not safe/harmful. Among the vasectomy adopters the major reasons given for dissatisfaction were 'physical discomfort' followed by 'bad after effects'. These were also the major reasons in respect of tubectomy in addition to 'harmful to health'. The main reasons given by adopters of IUD/Copper-T were 'physical discomfort,' 'harmful to health' and 'bad after effects'. The principal reasons for dissatisfaction given by users of condoms were 'not very safe,' 'satisfaction/pleasure decreases' and 'difficulty in practising' though some of the respondents give other reasons as well. For oral pills the chief reasons given were 'bad after effects' and 'harmful to health'. However, as will be observed from appendix table 7.2, in respect of each of the methods a significant proportion of the respondents gave 'other' or miscellaneous reasons. Considering the size of the sample respondents, therefore, the information collected on this aspect does not lead to very conclusive conclusions. Nevertheless, this does suggest that the reasons given for dissatisfaction in respect of different methods need study and examination by both medical researchers and the manufacturers of the family planning devices so that the factors contributing to the dissatisfaction of the users are minimised to the extent feasible.

#### *Methods Suggested*

7.08 The 529 sample adopters who reported that they had advised others about adoption of family planning were asked as to the methods suggested by them. Table 7.4 gives the distribution of these respondent adopters according to the method(s) suggested by them, on the basis of their experience, to others for adopting. It will be ob-

served from this table that tubectomy was suggested by the highest proportion (69.6 per cent) of such adopters followed by condom (31.6 per cent), vasectomy (28.4 per cent) and IUD/Copper-T (26.5 per cent). Oral pills and foam tablets were suggested by only 6.4 and 2.4 per cent respectively. Some adopters apparently suggested more than one method because, as brought out in Table 7.1, 47.2 per cent of adopters practised tubectomy, 25.2 per cent condom, 14.5 per cent IUD/Copper-T and 10.0 per cent vasectomy. The advice given by them to others was thus not confined only to the method adopted by them. However, this does not indicate that in terms of acceptability and popularity tubectomy ranked first followed by condom, vasectomy and IUD/Copper-T.

Table 7.4—Distribution of Adopters According to Family Planning Methods Recommended by Them to Others

Method recommended to others	Progressive districts	Non-progressive	All-districts
1	2	3	4
1. Tubectomy . . . . .	198(66.4)	170(73.6)	368(69.6)
2. Condom . . . . .	93(31.2)	74(32.0)	167(31.6)
3. Vasectomy . . . . .	94(31.5)	56(24.2)	150(28.4)
4. IUD/Copper-T . . . . .	76(25.5)	64(27.7)	140(26.5)
5. Oral pills . . . . .	21(7.1)	13(5.6)	34(6.4)
6. Foam Tablets . . . . .	0(0.0)	11(4.8)	11(2.1)
7. Others . . . . .	0(0.0)	1(0.4)	1(0.2)
Total No. of adopters who suggested to others . . . . .	298(100.0)	231(100.0)	529(100.0)

N.B.—1. Figures in brackets are percentages.

2. Some adopters suggested more than one method.

#### Target Age-Groups

7.09 In as much as for obtaining optimum results the family planning programme must identify the target group(s) to which its efforts should be specifically directed at, with this purpose in view the sample adopters were asked to indicate their age (i) at the time of their marriage, (ii) first adoption of a family planning method and (iii) at the time of the birth of their first child. The information (iii) was sought from female adopters in case, they were the respondents themselves and in case of male adopters the age of their wife was asked. Table 7.5 gives the distribution of adopters by broad age-groups at the time of their marriage and also at the time of their first adoption of a family planning method. Similarly, table 7.6 gives the age-group distribution of the mothers at the time of the birth of their first child.

Table 7.5—Distribution of Adopters by Age at the Time of (i) Marriage and (ii) First Adoption of Family Planning Method

Age-Groups (Years)	Age at the time of marriage			Age at the time of first adoption of a family planning method		
	Progressive districts	Non-progressive districts	All districts	Progressive districts	Non-progressive districts	All districts
1	2	3	4	5	6	7
1. Below 15 . . . . .	59(11.3)	57(11.4)	116(11.3)	0(0.0)	0(0.0)	0(0.0)
2. 15—24 . . . . .	421(80.5)	399(79.6)	820(80.1)	126(24.1)	98(19.6)	224(21.9)
3. 25—34 . . . . .	43(8.2)	43(8.6)	86(8.4)	312(59.7)	311(62.1)	623(60.8)
4. 35—45 . . . . .	0(0.0)	2(0.4)	2(0.2)	84(16.1)	85(17.0)	169(16.5)
5. 45 years and above . . . . .	0(0.0)	0(0.0)	0(0.0)	1(0.2)	7(1.4)	8(0.8)
Total No. of adopters . . . . .	523(100.0)	501(100.0)	1024(100.0)	523(100.0)	501(100.0)	1024(100.0)

N.B.—Figures in brackets are percentages.

Table 7.6—Distribution of Adopters (if Female) or the Wife of the Adopters at the Time of the Birth of the First Child

Age-Group (Years)	Progressive districts	Non- progressive districts.	All- districts.
1	2	3	4
1. Below 15 . . . . .	5(1.0)	10(2.0)	15(1.5)
2. 15—24 . . . . .	489(93.8)	457(91.4)	946(92.6)
3. 25—34 . . . . .	27(5.2)	33(6.6)	60(5.9)
4. 35—44 . . . . .	0(0.0)	0(0.0)	0(0.0)

N.B.—1. Figures in brackets are percentages.

2. Three adopters had no issue at the time of field canvassing.

7.10 It would be seen from table 7.5 that 91.4 per cent of the sample adopters had been married before they were 25 years of age and 11.3 per cent were married even before they were 15 years old. On the other hand, only 21.9 per cent of the sample adopters had first adopted a family planning method by the time they were 25 years old and another 60.8 per cent between the age of 25—34 years. Again as will be observed from table 7.6, 92.6 per cent of the mothers (adopters or their wives) reported the birth of their first child before the age of 25 years. Thus, whereas 91.4 per cent of the sample adopters were married and also had their first child by the time the female partner was 25 years of age, only 21.9 per cent, i.e., a little over one-fifth, of them had begun to practise family planning method by that time. In other words, from out of 936 sample adopters married by the age of 25 years only 224 or 23.9 per cent had adopted a family planning method till that age and the remaining 76.1 per cent had not done so. The prime target group of the family planning programme should, therefore, be the couples in the age-group below 25 years. That is to say, the family planning should begin with the nuptials, i.e., right from the consummation night. This is essential not only for control of population growth but also for proper spacing of the birth of the children\*.



\*It may be noted in this context that as shown in table 2.6 (chapter 2) 110 out of 141, i.e., 78 per cent of the selected respondents in the age-group below 25 years had begun to use one or the other family planning method at the time this study was launched in the field. The reference here is, however, to the 936 sample respondents who had adopted a family planning method before attaining the age of 25 and not to the adopters below the age of 25 at the time of canvassing.

## Chapter 8

### SUMMARY OF FINDINGS AND RECOMMENDATIONS AND AGENCY BY WHICH ACTION TO BE TAKEN

#### I. POSTS SANCTIONED AND VACANT

8.01 Whereas generally all the senior level posts in the Family Planning Bureaux/departments were found to have been filled up in all States, in the case of three categories of officials, viz., Social Scientist, Family Welfare and Evaluation Worker and Exhibition/Outdoor Publicity/Audio-Visual Officer, 22 to 25 per cent of the posts had not been filled up (Para 2.04)

8.02 At the State level, considerable variation was also noticed in the number of posts sanctioned in certain categories of staff. (Para 2.05)

8.03 In the case of junior level posts, such as Statistical Investigators and Family Welfare Field and Evaluation Workers, the variation observed in the number of sanctioned posts was larger. (Para 2.06)

8.04 At the district level, almost double the percentage (18 per cent) of the posts was found to be vacant as against 9.2 per cent of posts lying vacant at the State level. The vacancies at the district level were highest in the category of Family Welfare Field and Evaluation Workers and District Extension Educators, being as high as 33 per cent and 31 per cent respectively. (Para 2.09)

8.05 At the Primary Health Centre level, the total number of all vacancies of all the categories of posts worked out to 16.4 per cent which was only marginally lower than that at the district level (18 per cent). The highest percentage (22.2 per cent) of vacancies was in respect of the posts of Multipurpose Worker followed by Lady Health Visitor/Health Supervisor (20.5 per cent). About 14 per cent of the posts of Auxiliary Nurse-Midwife (ANMs) and 10 per cent of the posts of Medical Officers were also vacant. (Para 2.13)

8.06 The phenomenon of actual deployment of staff falling short of the sanctioned strength, particularly at the district and PHC levels, indicated that the degree of organisational coordination remained below the optimum and planned levels. (Para 2.15)

#### *Reasons for Posts Remaining Vacant*

8.07 The main reason for the posts remaining vacant at different levels was stated to be administrative delay. (Para 2.16)

8.08 In as much as the successful implementation of a crucial programme of national importance, like Family Welfare Programme, rests to a large extent on the full complement of staff being in position at all levels, it is imperative that ways and means should be found to cut down administrative delays in filling up of the posts. (Para 2.17)

8.09 Keeping in view the magnitude of the population to be serviced and the communication facilities available, the State Governments should review the strength of the staff required for the purpose at different levels of the operation of the programme and accordingly take steps to strengthen it. (Para 2.18)

8.10 Creation of posts alone is, however, not adequate. Available posts, new or on transfer, should be filled expeditiously. The district and junior level posts, being operational level posts, should be filled up with a sense of urgency. It should be the endeavour to fill up the posts falling vacant within an outer limit of three months. (Para 2.18)

#### II. TRAINING OF STAFF

8.11 Over 79 per cent of the staff at the State level and over 82 per cent at the district level had undergone special training in family welfare programme. However, about 25 per cent of the Family Welfare Field and Evaluation workers and 50 per cent of the Statistical Investigators at the district level had not received any training. (Para 2.22)

8.12 In the sample studied at the PHC level, 20 to 24 per cent of Medical Officers, Block Extension Educators, Lady Health Visitors, Multipurpose Workers and ANMs had yet to receive any orientation training. (Para 2.23)

8.13 For the successful implementation of the programme all offices concerned, particularly those at the junior levels, should be given suitable and adequate training in respect of both the background and concepts of the programme as well as methods and techniques of implementation. In fact, in the case of junior level staff the coverage under training should be cent per cent. (Para 2.26)

8.14 The required training needs to be imparted not only at the time of first appointment and posting, but also at regular intervals. For this purpose, it may be desirable to prepare a long-term roster of training in respect of all categories of staff, so that the staff can be sent in batches on rotation without affecting the normal working of the programme in the field. (Para 2.26)

8.15 All States should have a permanent training institute where different level staff could be sent for initial training and subsequent refresher and reorientation courses from time to time in their service career. (Para 2.26)

8.16 At reasonable intervals, the field staff should be provided opportunities to discuss and share their experiences of programme implementation amongst themselves in short duration seminars/workshops/group discussions etc. (Para 2.26)

### III. INFRASTRUCTURAL FACILITIES AND PROGRESS OF THE PROGRAMME

8.17 In as much as a larger number of sample villages from progressive than non-progressive districts\* were better placed in respect of their size (area as well as population), accessibility and availability of infrastructural facilities, such as education, recreation, communication, transport, and health/medicine, the extent of the spread of family planning in the sample villages from progressive districts was also better. In other words, the family planning programme had made a better progress in relatively bigger villages with better accessibility to medical/health facilities and having better infrastructural facilities. Therefore, in order to obtain faster results, the efforts under the family planning programme should be directed in a greater measure to villages of a bigger size and comparatively better served with infrastructural facilities of the type referred to earlier. At the same time, this analysis also suggests that greater provision of amenities and infrastructural facilities in the villages would provide a positive support to the wider spread and adoption of this programme. (Para 3.08)

### IV. PROFILE OF SAMPLE HOUSEHOLDS

8.18 The highest proportion of adopters (78.0 per cent), as on the date of canvassing, was in the respondents in the age-group 15—24 years, followed by the age-group 25—34 years (71.4 per cent.). In the higher age-groups, the percentage of adopters exhibited a sharp decline and that of non-adopters correspondingly increased steeply. (Para 3.10)

8.19 In the total sample for adopters the proportion of female adopters was nearly twice that of male adopters. This, *inter alia*, suggests the need for reaching out to the male population of rural areas in greater measures. (Para 3.11)

8.20 Whereas in the case of Hindus and Muslims the proportion of non-adopters was slightly higher than that of adopters, in the case of Christians and Sikhs the proportion of non-adopters was distinctly lower than that of adopters in the respective samples. (Para 3.12)

8.21 While adopters from all the cultural groups were using terminal as well non-terminal methods, the information gathered did not show any distinct preference within a cultural group for any of the two types of methods. (Para 3.13)

8.22 In the case of scheduled castes, scheduled tribes and backward classes the percentage of adopters using terminal methods was considerably higher than that of those using non-terminal methods. This indicates that these social groups had in general a greater preference for non-terminal methods. (Para 3.15)

8.23 In the residual category of "others" the percentage of adopters using non-terminal methods was considerably higher than those using terminal methods indicating a comparative preference for the former type of methods. (Para 3.15)

8.24 The extension efforts to cover more and more people under family planning could take note of the comparative preference for terminal/non-terminal method by people from different social groups. (Para 3.15)

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\*For the definition of 'progressive' and 'non-progressive' districts see para 1.07.  
12 P.C. 7.



8.25 The level of formal education as such came out as having little or no influence on the adoption of family planning measures. (Para 3.16)

8.26 In the two occupational groups, viz., cultivators and services, the percentage of adopters using non-terminal methods was distinctly higher than those using terminal methods. On the other hand in the occupational category of labourers the percentage of sample adopters using terminal methods was appreciably higher than those using non-terminal methods. This suggests that in the propagation of family planning methods among these occupational groups, their comparative preference for terminal and non-terminal methods should be taken into account. (Para 3.18)

8.27 The percentage of adopters in different income brackets did not show any marked variation from the percentage of non-adopters in the corresponding income brackets. In other words, income levels had little or no determining influence on the adoption or otherwise of family planning measures. Adoption of family planning measures by eligible couples was due to factors other than that of income. (Para 3.20)

8.28 As between the sample adopters of terminal or non-terminal methods of family planning the income factor seemed to have some relevance. Whereas both types of family planning methods were being practised by respondents in all the income groups, those in the income brackets of Rs. 6,000 or less had a greater preference for terminal methods. On the other hand those in higher income brackets tended to prefer non-terminal methods (Para 3.21)

8.29 For securing better results under the family planning programme, comparative preference for terminal and non-terminal methods in the lower and higher income brackets respectively should be duly taken into account. (Para 3.21)

## V. EXTENSION METHODS AND MOTIVATION

8.30 During the period under reference, viz., 1980-81, 1981-82 and 1982-83 (upto December, 1982), the coverage of villages, under different extension methods to popularise family planning increased significantly in 1982-83 as compared to in 1967-68. (Para 4.03)

8.31 All villages in all the States should be covered under family planning camps at least every alternative year and film shows should be organised in each village at least twice a year especially around the time the crops have been sown and cultivators and labourers have more leisure hours on hand. It is around this time that the extension efforts under the family planning programme have to be extra vigorous in the countryside so as to be more effective and result oriented. (Para 4.03)

8.32 Both the frequency of different extension methods used and the coverage of villages under them was generally quite high. However, excepting displaying of posters and distribution of publicity material, the distribution of villages covered under other extension methods did not show any significant increase in 1982-83 (upto December, 1982) over 1980-81. (Para 4.11)

8.33 Since as high as 88.3 per cent of total respondents were in contact with one or the other mass media and the proportion of respondents in contact with mass media in progressive districts was appreciably higher as compared to non-progressive districts, it is obvious that mass media has a significant role to play in generating adequate degree of awareness among rural people for the adoption of family planning. (Para 4.14)

8.34 Only 9.4 per cent of sample respondents reported contact with pamphlets and folders on family planning. This indicated that the use of pamphlets/folders as a mass media extension tool for propagation of family planning in rural areas has only a limited potential. (Para 4.15)

8.35 Of all the major mass media, radio emerged as the single most important medium. It should therefore, continue to be extensively used to reach and educate the target group of population in respect of the family planning programme and its related aspects. (Para 4.16)

8.36 In view of the increase in television coverage within the country, this powerful audio-visual medium along with the cinema, should be put to fuller and purposeful use for propagating family planning than what has been the case hitherto. (Para 4.16)

8.37 Newspapers, pamphlets/folders, etc., as a mass contact medium it would seem could be utilized more effectively in States/areas with a high level of literacy percentage, such as Kerala (Par. 4.16)

8. 38 Of the five categories of officials canvassed, viz., Medical Officers, Lady Health Visitors, Block Extension Educators, Health Assistants/Family Welfare Health Assistants (FWHAs) and Auxiliary Nurse-Midwives (ANMs), the first four categories of officials did not visit from 17 to 22 per cent of the selected villages and the fifth category of officials viz., ANMs, from 9 to 10 per cent of them. If the headquarter villages and villages in respect of which the relevant posts were vacant are not excluded for purposes of calculating the percentage of villages not visited, these percentages would be still higher. State Governments should, therefore devise monitoring arrangements by which senior officers at different levels are apprised of the relevant details in this regard. (Para 4. 17)

8. 39 In the case of villages difficult of access, the State departments concerned should make arrangements for transport/stay of officers in such areas. (Para 4. 17) (Also see Para 8. 82)

8. 40 The frequency of visits, whatever it is, should be a pre-determined number and so arranged that during a week either one or the other medical personnel visits a village. This can be worked out and coordinated either at the PHC or the district level. (Para 4. 18)

## VI. ROLE OF VOLUNTARY AGENCIES

8. 41 The involvement of village and local leaders, school teachers, panchayats and voluntary organisations in the family planning programme in terms of actual help and in terms of comprehensive coverage of the selected villages, was woefully inadequate. Since family planning programme has been envisaged as a voluntary programme, and since non-voluntary involvement in it is counter-productive, ways and means should be found to involve, in much larger measures than hitherto, village and local leaders, panchayats, school teachers and voluntary organisations in family planning and related activities in all villages. (Para 4. 20)

8. 42 The involvement of village and local leaders, school teachers, panchayats and mahila mandals/yuvak mandals in motivational work, in organising mass campaigns/meetings, and in extension/health education should be channelised by planned efforts to this end. (Para 4. 21)

## VII. AWARENESS ABOUT FAMILY PLANNING

8. 43 Almost all eligible couples were aware of family planning. (Para 5. 02)

8. 44 Other things being the same, the length of the period of contact through audio, visual or personal media was of little or no significance in the matter of the adoption of family planning. In other words, the number of eligible couples adopting family planning was not contingent upon the duration of their awareness. (Para 5. 03)

8. 45 Family planning staff and motivators, as the first source of information did not seem to have been as effective in the case of adopters as they were in the case of non-adopters. 'Spouse' and 'relatives and friends' and 'mass media' as the first sources of information, seemed to have been quite effective in creating awareness about family planning among adopters. In the case of adopters, other adopters were comparatively more important as a first source of information than doctors and motivators taken together who were directly and officially concerned with the propagation of family planning. The other sources, such as meetings, camps and fairs, community leaders and block staff, did not play any significant role as a first source of information. (Para 5. 04)

8. 46 There is need for introspection as to the tangible role of these agencies, viz., of family planning staff, motivators, and doctors, as the first source of information. Greater reliance may, therefore, have to be placed on 'spouse', 'relatives and friends' and 'mass media', i.e., non-official channels, as a first source of information besides of course the family planning staff. (Para 5. 04)

8. 47 The dissemination of information about family planning was being directed to all people under the programme. (Para 5. 07)

8. 48 The non-adoption of family planning methods was not for want of knowledge about these on the part of non-adopters but because of other reasons. (Para 5. 07)

8. 49 The knowledge of different family planning methods among adopters as well as non-adopters was mainly confined to terminal methods of tubectomy and vasectomy followed by the non-terminal methods of IUD/Copper-T and condom in that order of importance. This could be taken to reflect the relative degree of emphasis on these methods in the operation of the programme. It is surprising that the rhythm method

was known to only 1.2 per cent of adopters and 0.2 per cent of non-adopters. Likewise, MTP was known to 0.4 percent of adopters and 0.2 per cent of non-adopters. This points to a rather lop-sided approach in the matter of propagation of different family planning methods. (Para 5.10)

8.50 The heavy and practically exclusive emphasis on terminal methods of tubectomy and vasectomy, also sheds some light on a pertinent point as to why there is such a larger percentage of non-adopters despite the family planning programme having been in operation for over three decades now. Obviously, if a large enough percentage of eligible couples did not want to 'terminate' their option to have children later on and were not well informed regarding the other non-terminal methods available, especially the MTP methods, they remained non-adopters due to the sheer lack of knowledge as to the availability of methods which could be suitable and acceptable to them. (Para 5.10)

8.51 It should be the endeavour of the agencies/functionaries concerned with the family planning programme to inform the eligible couples on all methods of family planning, clearly differentiating between the 'terminal' and 'non-terminal' options available to them, instead of putting all out emphasis (in terms of persuasion and incentives) on terminal methods, simply because these happen to be certain and irrevocable. (Para 5.11) (Also see Para 8.57).

8.52. If it is known to the eligible couples that there are methods of family planning which make the option of revocability available to them, this will go a long way in the matter of overcoming their hesitations and fears in respect of family planning. In matters so personal and emotive as marital relationship and begetting children, individual couples indeed desire full freedom of choice rather than to accept denial voluntarily or under the persuasive influence of incentives or media (Para 5.11)

8.53 A main plank of the efforts to spread knowledge of family planning should be to clearly explain to all eligible couples that if and when a particular non-terminal method fails and/or an unwanted pregnancy takes place, the foolproof MTP method would still be available. The knowledge regarding the availability of MTP method should help induce a significant proportion of non-adopters to adopt at least non-terminal methods. (Para 5.11)

8.54 The non-adopters were almost as knowledgeable and convinced about the advantages of family planning as the adopters. Thus, in so far as the generation of awareness for the need for family planning is concerned, the family planning programme has done its part. (Para 5.12)

8.55 Those who went in for family planning did so for personal and economic reasons and the incentives provided under the programme were, by and large, an inconsequential factor in decision making. This suggests that essentially the rationale and the emphasis of the planning family planning programme should be increasingly oriented towards the provision of adequate facilities and necessary supplies either free or at nominal cost well within the reach of all sections of the population. (Para 5.13) (Also see Para No. 8.76)

8.56 Economic messages (as different from cash incentives) registered well in the minds of eligible couples and, therefore, these could continue to be used. (Para 5.15) (Also see Para 8.66)

8.57 The views of non-adopters to the messages on the family planning methods were quite divided. Where-as IUD/Copper-T was favoured by 49.1 per cent, vasectomy was not favoured by 49.5 per cent of non-adopters (who had expressed their reaction in respect of these messages on family planning methods). On the whole, the non-adopters did not favour the terminal methods and, conversely, favoured the non-terminal methods. It again brings out the need to popularise non-terminal methods as equally useful family planning methods to control family size. (Para 5.16) (Also see Para Nos. 8.50 to 8.52)

## VIII. ACCEPTANCE AND ADOPTION

8.58 In the case of as high as 76.3 per cent of the adopters reporting time-lags, the time-lags involved between awareness and adoption varied as widely as two to eight years and more. This is indicative of a discouragingly long time-lag, or the slow rate of adoption of family planning by the couples. With such a long time lag the family planning programme obviously cannot make the desired impact on reducing the reproduction rate. (Para 6.02)

8.59 The focus of the efforts under the programme has to be on reducing the time-lag between acceptance and adoption to the minimum. In fact, once an eligible couple has accepted the usefulness and the need for family planning, there should practically be no time-lag whatsoever thereafter between acceptance and adoption. (Para 6.03)

8.60 The time-lag between awareness and acceptance should also be reduced drastically. This points to the need for evolving an effective and well-thought out strategy for the propagation of family planning whereby time-lags are greatly reduced and eliminated. Such a strategy will have, apart from aiming to remove the factors responsible for the wide time-lags, also to concentrate on advocating family planning methods better suited and more acceptable to different target groups of the couples in the reproductive age-groups (Para 6.04)

8.61 The two or three stages, namely that of awareness, acceptance and adoption, through which a couple is presumed to pass before adopting family planning methods were, in effect, one single phase and should, therefore, be treated as such. That is to say, the efforts shall specifically be to reduce the time-lag between acceptance and adoption to a minimum. This is also desirable because the longer the time-lag between acceptance and adoption the lower would be the number of eligible couples adopting family planning methods per year and, therefore, the cost of persuading all the eligible couples to adopt family planning methods would also be correspondingly higher. (Para 6.05)

### *Reasons for Time-lags*

8.62 The most important reason for time-lag between awareness and acceptance as well as between acceptance and adoption, as given by 54.5 per cent and 35.8 per cent of the respective respondent adopters was 'fears and misconceptions'. 'Desire for more children' was the reason given for the time-lag between awareness and adoption by 42.4 per cent of the respondent adopters and for the time-lag between acceptance and adoption by 28.3 per cent of the respective respondent adopters followed by 'discouragement from friends, relatives and spouse' by 25.8 per cent of the respondents for time-lag between awareness and acceptance and by 29.1 per cent between acceptance and adoption. The fourth main reason, viz., 'medical and health grounds', was given by 17.4 per cent and 28.4 per cent of the respective respondents. (Para 7.06)

8.63. Since 'fears and misconceptions' was given as a reason by 54.5 per cent of the respondent adopters for time-lag between awareness and acceptance and by about 36 per cent of the respondents for the time-lag between acceptance and adoption, it is evident that the propagation of the family planning programme was not delivering the message of family planning as efficiently and as effectively as required. It is therefore, important that ways and means should be found not only to fully and quickly convince the couples about the desirability and usefulness of adopting family planning but also to remove and dispel the fears and misconceptions several of them may have about family planning methods. For convincing couples and dispelling their fears, it is necessary that both husband and wife are approached and preferably together. Convincing one of the partners only should not be considered enough. For this purpose the strength of the female staff engaged in this work at various levels and in different capacities should be adequate (Para 6.07) (Also see para 8.81)

### *Reasons for Non-adoption by Non-adopters*

8.64 The reason associated with 'fears and mis-conceptions' accounted for as many as 61.1 per cent of the sample respondents not adopting family planning methods. The same factors, 'fears and misconceptions', accounted for the time-lag between awareness and acceptance among 54.5 per cent of the adopters and for 35.8 per cent of adopters for the time-lag between acceptance and adoption 'Desire for more children' was stated as a reason by 44.3 per cent of the sample non-adopters. This reason again was also the other reason mentioned by adopters for the time-lag between awareness, acceptance and adoption respectively. Objection by spouse/discouragement by relatives and friends and 'cultural and religious' reasons were the other two main reasons for the non-adoption of family planning methods by the sample non-adopters. These were also the other important reasons for time-lags given by the adopters. The marked similarity between the reasons for non-adoption among non-adopters and for time-lags among adopters positively suggests that the same type and quality of effort is required both to make the adoption of family planning methods more effective among adopters and to secure their greater adoption among non-adopters. (Para 6.08)

8.65 Some of the reasons given by non-adopters, such as the family planning 'harmful to health', 'no faith in family planning methods', 'no knowledge of family planning methods', reflect that the extension efforts made by the staff employed under the family planning programme needs to be considerably improved both as to their quality and content in order to remove misgivings and to impart correct knowledge about family planning. (Para 6.08)

### *Reasons for Adoption*

8.66 Of 1024 adopters canvassed, 49.6 per cent adopted family planning for mainly economic reasons; 17.4 per cent on health and medical grounds; 4.0 per cent because they found the recommended methods easy to adopt and reversible, if desired; and the remaining 29.1 per cent for other general reasons. Among general reasons given 'small family happy family' came out as having the widest appeal. This suggests that it is a distinct stress on these advantages of family planning which would evoke the maximum response to the message of family planning programme. (Para 6.09)

### *Voluntariness of Adoption*

8.67 While 97.4 per cent of the respondents said they had adopted family planning voluntarily, 2.6 per cent said that it was not voluntary on their part. Even though the percentage of those who felt they were made to adopt family planning non-voluntarily was insignificant, in the wider interests of the programme it would seem highly desirable that the methods and techniques of propagation do not at all detract from the voluntariness of the programme. (Para 6.10)

### *Adopters as Extension Agents*

8.68 On an average an adopter had talked on the subject of adoption with 5.4 persons and about eighty per cent (4.3 persons) had followed the advice given. This indicates not only a very high multiplier effect but also that the adopters were and can play the role of good, voluntary extension agents of the family planning programme. In as much the advice of those who have actually adopted family planning and their experience of the methods used can be much more convincing than only guidance and education, ways and means should be devised to make effective use of adopters to the maximum extent to propagate family planning among non-adopters and thereby enhance the impact of the programme. Apart from the efforts in various other directions, a scheme could be devised whereby adopters could be engaged and retained at a reasonable fee, or by giving some other suitable incentive, to work as motivators. (Para 6.11)

### *Role of Incentives*

8.69 As many as 63.8 per cent of the total sample adopters had received cash/kind incentives for adopting family planning methods (which in a large percentage of cases meant undergoing vasectomy/tubectomy). About 56 per cent of the total sample adopters got cash incentives and 7.9 per cent both cash and kind. The percentage of adopters having received incentives in kind was insignificant. (Para 6.12)

8.70 Of the adopters who got cash incentives, 54.4 per cent got a cash incentive of less than Rs. 105 each and 18.5 per cent got a cash incentive of Rs. 80 or less. About 34 per cent got an incentive of between Rs. 106-150. Those who got a cash incentive of Rs. 150 or more comprised 11.8 per cent. Taking all the adopters who received cash incentive together, the cash incentive came to Rs. 127.20 per adopter. Only three respondents reported having received the incentive in kind only. The kind incentive reported to have been received by them was found to be neither significant nor plausible. For those who received both cash and kind incentives, the average quantum worked out to Rs. 260.40 per person. (Para 6.13)

8.71 Only about one-third of the adopters who had received incentives said they were satisfied with the incentives offered to them; another about one-third of them said they were not, and the rest expressed no view. (Para 6.14) (Also see Para No. 8.55)

8.72 Of the adopters who gave suggestions, 89.0 per cent said that the incentive amount should be more. A little over 42 per cent of the suggestions were for giving preferential medical treatment and 21.7 per cent for full compensation for loss of wages. While 12.9 per cent of the suggestions were that free transport and free accommodation should be provided in a PHC/hospital, 4.4 per cent were for according priority for agricultural loans/supplies of agricultural inputs, etc. Only 1.3 per cent of the suggestions made were for longer special leave. (Para 6.14) (Also see Para 8.80)

8.73 If the rationale behind the provision of compensation is only removing the hindrance of transitory factors like loss of wages and costs involved in travel, enforced absence from work, etc., which could come in the way of the adoption of a suitable family planning method, then the quantum of incentive/compensation given should be more closely related to these aspects. On the other hand, if the purpose is also to provide an inducement for going in for family planning then the incentive should be reasonably attractive. Incentives to be effective have to be not marginal and niggardly but substantial and alluring. The incentive amount offered for vasectomy/tubectomy could, for instance, be a sum of money equivalent to about 3 to 4 months wages and for the insertion of IUD 2 to 3 weeks wages of a daily labourer. In case of IUD also it should be a one-time incentive only. (Para 6.15)

8.74 In the case of daily wage/casual workers, etc., they should be given full compensation for the loss of wages as well as other direct and indirect costs incurred by them in addition to the prescribed incentive money for vasectomy/tubectomy/insertion of IUD. For the other classes of employees, in whose case money incentive or the costs entailed are not a very material consideration, concessions such as a longer period of leave should be considered. (Para 6.15)

8.75 This also leads to the point that if the choice of a particular method is to be left to the individual adopters, a differential in the prescribed rates of incentives for adopting particular non-terminal methods is scarcely understandable. Instead the accent should be on provision of more adequate facilities for those who find these methods more suitable or need them. For example, in areas where industrial/agricultural labourers are in a majority special family planning clinics should be opened with adequate facilities for vasectomy, tubectomy, post-operation care, follow-up measures, etc. (Para 6.15)

8.76 The quantum of compensation/incentive for those going in for vasectomy, tubectomy and IUD insertions should not be the same for all categories of the adopters of these devices and should instead be related in a suitable manner to the stage at which these methods are adopted. If the provision of the incentives is considered desirable or necessary, the amount of the incentive should be considerably higher if these methods are adopted after the birth of the first child, less after the second child and the lowest after the third child. The case for evolving such a graded system of incentives rests on the ground that it is the early adoption of an effective family planning method which deserves to be compensated for rather than its adoption at a late stage when a couple has already got two or three children. That is to say, the distinct emphasis of any system of incentives should be on restricting the number of children and population growth and not merely on the adoption of a terminal method at any stage. (Para 6.16)

#### *Other Observations and Suggestions*

8.77 A majority of the respondents, ranging between 56.3 and 64.3 per cent, expressed the view that the working (of the relevant aspects) of the programme was satisfactory/adequate. However, some 30 per cent of the respondents considered that the availability of the family planning staff at the village level, frequency of contact/visits by family planning staff and follow-up after adoption were not adequate or satisfactory. About 28 per cent of the adopters were also of the view that the timely availability of supplies was not satisfactory; 22 per cent considered that the quantity of family planning devices/medicines was not adequate; and 15.7 per cent expressed the opinion that the quality was not satisfactory. Only a very small percentage of the sample respondents thought that the operation of the family planning programme vis-a-vis the relevant aspects had deteriorated since 1980. (Para 6.18)

8.78 In order to ensure that there is no shortage of supplies of contraceptives in any of the family planning units, PHCs, etc., it should be made obligatory on the part of these units, etc., to maintain at all times a stock of one month's requirements in advance. (Para 6.30)

8.79 While all efforts should be made to improve the quality of contraceptives, every reported case of the defective quality of contraceptives should be got fully investigated at a responsible level both with a view to institute remedial action and punitive action, where necessary, to minimise further quality defects in contraceptive devices. (Para 6.31)

8.80 The follow-up facilities should be suitably strengthened so that these are adequate and regularly available. A *modus operandi* should be evolved whereby prompt treatment is given in cases of complaint and thereafter regular follow-up is done. To this end, all cases of vasectomy, tubectomy and IUD should be regularly reviewed at stipulated intervals on a continuous basis. The follow-up action taken should be entered in the file-register of each case. The spacing of this follow-up could be gradually increased with the passage of time if there are satisfactory results and an absence of complaints, or shortened if complications arise and frequency of complaints increase. The file-register should be closed only when there is no post-vasectomy/tubectomy/IUD complaint for a stipulated period of time. (Para 6.32)

8.81 While to an extent the desired frequency of contact of the family planning staff with the villages and more frequent domiciliary visits by them may be possible by careful harnessing of the available resources and by exercising proper checks and inspection to ensure that the stipulated number of visits to villages, etc., are in fact made by the concerned staff, where necessary the number of villages per PHC/Sub-Centre may be suitably reduced so that family planning facilities, even for terminal methods, become available to all villagers within bullock-cart distances. (Para 6.33) (Also see Para 8.63) and 8.82)

8.82 It should also be the endeavour of the authorities responsible for the implementation of the programme to provide to its field staff residential accommodation at the place of their posting and also free transport facility

for undertaking visits to villages under their jurisdiction. At the same time, it may be made compulsory for the field staff to reside at the place of posting. In cases where it is not found feasible to provide residential accommodation a suitable hardship allowance may be given to the concerned field staff. (Para 6.34) (Also see para 8.39)

## IX. METHODS PRACTISED AND SUGGESTED

8.83 Terminal methods of tubectomy and vasectomy were practised by 57.2 per cent of sample adopters, and non-terminal methods, i.e., condom, IUD/Copper-T and oral pills, were practised by about 42.8 per cent of adopters. Tubectomy was practised by the largest percentages of adopters (47.2) followed by condom (25.2 per cent), IUD/Copper-T (14.5 per cent), vasectomy (10.0 per cent) and oral pill 3.1 per cent). (Para 7.02)

8.84 Out of a total sample of 664 women adopters, 483 (72.7 per cent) practised tubectomy. Out of a total of 360 male adopters canvassed, 258 (71.7 per cent) practised the condom method and only 102 (28.3 per cent) the vasectomy method. Thus, as between terminal and non-terminal methods, the former type of methods were preferred by the majority (57.2 per cent) of the sample adopters, tubectomy amongst women and condom amongst men. (Para 7.02)

8.85 The rise in the proportion of adopters of tubectomy as a terminal method of family planning, and vasectomy as a terminal method being much less preferred, shows that either women were more family planning minded, or that the sacrifices involved was on the part of the female partners. (Para 7.03)

### *Reasons for Preferences*

8.86 Among those who used oral pills and condom, 87.9 and 83.8 per cent respectively gave comfort and convenience of using these methods as the reasons. IUD/Copper-T, condom and oral pills were also preferred by 56.1, 49.3 and 48.5 per cent of the adopters because these methods were good for spacing and were reversible. Vasectomy and tubectomy were preferred by 45.1 and 48.5 per cent of the respondents respectively as they considered these better and more reliable for preventing pregnancy. Another 69.6 and 48.6 per cent gave comfort and convenience of use as the reason for preferring these two respective methods. Fortysix per cent of the sample adopters gave this reason for preferring IUD/Copper-T. Advice by spouse, relatives and friends, as well as health staff, was the reason given by 29.4 per cent of the sample adopters for vasectomy, 46.9 for tubectomy, 30.4 per cent IUD/Copper-T, 13.7 per cent for condom and 18.1 per cent for oral pills. Reliability and comfort and convenience of use, thus, emerged in general as the major reasons for preferring different methods. On the other hand, money incentives came out as a reason of no consequence. (Para 7.04)

8.87 The reasons given by the sample respondents for preferring different family planning methods provide an idea of the strong points in favour of particular methods which could be kept in view in promoting their popularity. Thus, condom and oral pills, as methods of family planning would sell best for reasons of comfort and convenience of use followed by being good for spacing and being reversible. Vasectomy and tubectomy would have greater appeal for 'comfort and convenience of use' followed by being 'better and reliable'. IUD/Copper-T's strongest point for popularisation would seem to be its being 'good for spacing and reversible' followed by 'comfort and convenience of use'. (Para 7.05)

### *Reasons for Satisfaction/Dissatisfaction*

8.88 The number of those satisfied with the method adopted by them ranged between 81.0 and 87.3 per cent, the highest percentage of satisfied adopters being in the case of those who had adopted vasectomy. The percentage of 'not satisfied' was comparatively significant only in respect of those using IUD/Copper-T, condom and oral pills—9.5, 8.1 and 9.1 per cent respectively. (Para 7.06)

8.89 Out of 161 adopters who were dissatisfied with the family planning method used by them, 72 (44.7 per cent) used tubectomy, 49 (30.4 per cent) condom, 21 (13.0 per cent) IUD/Copper-T, 13 (8.1 per cent) vasectomy, and 6 (3.7 per cent) pills. (Para 7.07)

8.90 The reasons given for dissatisfaction indicated that this was, broadly speaking, on three major counts, viz., (i) physical discomfort, (ii) less pleasure giving, and (iii) not safe/harmful. Condom was found fault with on all these three counts. Among the vasectomy adopters the major reasons given for dissatisfaction were 'Physical discomfort' followed by 'bad after effects'. These were also the major reasons in respect of tubectomy in addition to 'harmful to health'. The main reasons given by adopters of IUD/Copper-T were 'physical discomfort' 'harmful to health' and 'bad after effects'. The principal reasons for dissatisfaction given by users of condoms were 'not very safe', 'satisfaction/pleasure decreases', 'difficulty in practising' though some of the respondents gave other reasons as well. For oral pills the chief reasons given were 'bad after effects' and 'harmful to health'. However, in respect of each of the methods a significant proportion of the respondents gave 'other' or miscellaneous

asons. Considering the size of the sample respondents, therefore, the information collected on this aspect does not lead to very conclusive conclusions. Nevertheless this does suggest that the reasons given for dissatisfaction in respect of different methods need study and examination by both medical researchers and the manufacturers of the family planning devices so that the factors contributing to the dissatisfaction of the users are minimised to the extent feasible. (Para 7.07)

#### *Methods suggested*

8.91 Tubectomy was suggested by the highest proportion (69.6 per cent) of adopters followed by condom (31.6 per cent), vasectomy (28.4 per cent) and IUD/Copper-T (26.5 per cent). Oral pills and foam tablets were suggested by only 6.4 and 2.4 per cent respectively. Some adopters apparently suggested more than one method. The advice given by them to others was thus not confined only to the method adopted by them. However, this does indicate that in terms of acceptability and popularity, tubectomy ranked first followed by condom, vasectomy and IUD/Copper-T. (Para 7.08)

#### *Target Age Group*

8.92 Whereas 91.4 per cent of the sample adopters were married and also had their first child by the time the female partner was 25 years of age, only 21.9 per cent, i.e., a little over one-fifth, of them had begun to practise family planning method by that time. From out of 936 sample adopters who had been married by the age of 25 years only 224, or 23.9 per cent, had adopted a family planning method till that age and the remaining 76.1 per cent had not done so. A Prime target group of the family planning programme should, therefore, be to reach all the couples in the age-group below 25 years. That is to say, the family planning should begin with the nuptials, i.e., right from the consummation night. This is essential not only for control of population growth but also for proper spacing of the birth of the children.\*

### X. AGENCY BY WHICH ACTION TO BE TAKEN ON RECOMMENDATIONS MADE

8.93. Broadly speaking only two agencies, viz., (i) the Ministry of Health and Family Welfare at the Centre and (ii) the Family Welfare Bureau, Department of Health in the States are required to take action on the recommendations made in this Report. Recommendations Nos. 8.73, 8.74, 8.76, 8.90 and 8.92 mainly concern the Union Ministry. The following recommendations concern the Union Ministry as well as the Family Welfare Bureau/Department of Health in States. 8.08, 8.10, 8.17, 8.35, 8.36, 8.37, 8.46, 8.55, 8.56, 8.57, 8.58, 8.66, 8.68, 8.75, 8.79, 8.81 and 8.87.

8.94 The action on the recommendation listed below is primarily to be taken by the Family Welfare Bureau/Department of Health in States. 8.09, 8.13, 8.14, 8.15, 8.16, 8.19, 8.24, 8.26, 8.29, 8.31, 8.38, 8.39, 8.40, 8.41, 8.42, 8.51, 8.53, 8.61, 8.63, 8.65, 8.67, 8.68, 8.78, 8.80, 8.81, 8.82 and 8.87.

\*It may be noted in this context that as shown in table 3.6 (Chapter 3) 110 out of 141, i.e., 78 per cent of the selected respondents in the age-group below 25 years had begun to use one or the other family planning method at the time this study was launched in the field. The reference here is however to the 936 sample respondents who had adopted a family planning method before attaining the age of 25 and not to the adopters below the age of 25 at the time of canvassing.



## **Annexure-A**

### **Evaluation of the Family Planning Programme : Reports of Assessment Teams and the Panel of Consultants (March, 1965)**

#### **Main Observations and Suggestions**

—Lack of sufficient priority for the family planning programme hindered the development and implementation of the programme in the States.

—States should be assured of Central assistance for a period of ten years irrespective of the plan period.

—The Central Family Planning Organisation should be established as a Directorate General of Family Planning in the Health Ministry, and the Director General of Family Planning conferred the status of an ex-officio Additional Secretary to Government.

—A Family Planning Executive Board should be set up as a semi-autonomous body. The Board should be able to exercise full powers of financial sanction and administrative action, including appointment of staff, within the annual budget allocation for the programme.

—An outline of a scheme for a substantial strengthening of the staff of the Central Family Planning Organisation was suggested.

—Decentralisation of powers to the States was recommended particularly, relating to the sanction of grants to voluntary organisations and local bodies.

—The States needed technical help on a short term basis from the Centre as well as from other States. For this purpose setting up of a "State consultant panel" made up of outstanding State workers who have had valuable experience in special aspects of the programme was proposed.

—The sanctioned staffing pattern for the State Family Planning Bureau was considered inadequate. Higher status for the State F.P. Officer was recommended.

—Setting up of Family Planning Bureau was recommended in every city or town of over 10 lakh population.

—Appointment of honorary family planning leaders and payment of honoraria were not favoured, when no such payment was envisaged for the Panchayati Raj and other leaders.

—Because of the shortage of women medical officers for provision of IUCD services in rural areas, a special arrangement was suggested whereby the post of female medical officer could be retained in some blocks in each district, and the rest be located at the district level under the District Family Planning Medical Officer. They would be required to make scheduled visits regularly to the block family planning units and other centres, to provide IUCD services.

—The proposed network of State Family Planning Training Centres should be vigorously developed.

—The facilities of the four regional family planning training institutions should be enabled to provide assistance to the States in their region in the development of a "master plan for training".

—Schools of Social Work should give special attention to preparing their students as likely recruits to posts of family planning extension educators at District and State levels.

—The need for careful educational work at the time of IUCD insertion or sterilization operation was emphasised.

—The need for popular national and local leaders giving much stronger support to the small-family idea was emphasised.

--Three techniques of contraception—sterilization, IUCD and condom were emerging as methods which met the criteria of effectiveness and popularity on a large scale.

--Voluntary sterilization had proved capable of popularity on a mass scale. It deserved full, continuing promotion as part of the programme. On the other hand, enthusiasm about this method had in some States led to neglect of other high-priority aspects of the family planning programme.

--The "camp" method of providing sterilization services, in which the operations were done by a special team brought to an area for the purpose, had proved highly satisfactory.

--Facilities for female sterilization operations done after delivery were easily available only in a few maternity hospitals/centres.

--The State should be allowed to set up patterns of compensation or payment which, after careful consideration, they feel best suited to their own local situation.

--Financial supports such as the above were to be treated as ad-hoc measures to gain as much momentum as possible for the programme. Further consideration needed to be given to the manner in which these incentives could be most efficiently used henceforth, and how they might be ultimately tapered off in future.

--Strong central encouragement should be given to extension of the system of depot-holders by all urban and rural family planning units.

--The State Bureaux of Vital and Health Statistics should be strengthened as rapidly as possible and headed by senior statistical personnel to give needed leadership in this most critical aspect.

--Administrative data for progress analysis and implementation review are still imperfect. A special study team or working group be constituted to work out an improved system of reporting of progress and administrative intelligence data.

Henceforth, an annual evaluation of the programme should be aimed at.



## **Annexure-B**

### *Family Planning Programme in India - An Evaluation (1970)—Brief Summary and Main Findings.*

1. The evaluation of the family planning programme was done in two phases. In the first phase, a general purpose enquiry was taken up during September-December, 1968 covering the availability of services, scope and nature of mass education and communication programme, staff position at different levels, the achievements, the assessment of knowledge, attitude and reaction of local leaders and general respondents, functioning of Regional Training Centres etc. The sample coverage for the general purpose study extended to 35 districts, 69 rural family planning centres, 15 Regional Training Centres, 350 villages, about 7,000 respondents (including over 900 local leaders) and 271 family planning staff spread over all the States and one Union Territory, i.e., Himachal Pradesh. Even though the sample was slightly weighted in favour of areas where achievements had been comparatively better than others within a State, but in view of the fact that the progress of the family planning programme was uneven between the States, the sample is expected to be adequate for a proper representation of the differential achievements and problems in the different parts of the country.

2. The second phase of the study undertaken during March to May, 1969, was concerned with the study of adopters of vasectomy, tubectomy and IUCD. Data were collected from both rural and urban areas in 9 districts where achievements was supposed to be much better. In all, the working of 36 rural clinics and 27 urban clinics was studied, besides interviewing about 6,000 adopters distributed in 180 villages and 18 cities and towns. In addition to this, a sub-sample of 1372 spouses was interviewed in order to check some of the responses obtained from the adopters. As desired by the Department of Family Planning, an interim report was prepared in April, 1969 based on the data collected during the first phase of the study for the use of the U.N. Evaluation Team on Family Planning.

#### *The Task*

3. Both the rate of progress and the achievement in absolute terms in recent years are quite significant. About 5 million sterilizations were reported during the period April, 1965 till March, 1969 compared to a total of about 1 million in the 14 years prior to 1965. So also, the achievement in respect of IUCD since 1965, is noteworthy and is of the order of 2.8 million. Although the overall picture is somewhat optimistic, the programme had not spread evenly among the different States. Besides, considering the goal of reducing the birth-rate to 25 per thousand population in the 10-year period ending with 1978-79, there is hardly any room for complacency in the results achieved so far. It calls for greater efforts both quantitatively and qualitatively. The task is not only to sustain the present tempo of the programme but also to escalate it in order to reach the demographic goals set, especially in view of the recent decline in rate of acceptance of IUCD and vasectomy. It is envisaged that by 1972-73 there would be 15 million acceptors which is about five times the present rate of achievement. The study has thrown up a number of leads which would help in stabilizing the different components of the programme in order to reach it to a much larger proportion of eligible couples.

#### *Future Prospects*

4. From the overall picture of accomplishment over the last three years, it may not be appropriate to conclude that the plateau has been reached in respect of vasectomy or IUCD programme in the large majority of the States or districts as may be evident from the data collected from the sample districts and blocks. Therefore, there is scope for accelerating the vasectomy programme in the next few years. Similarly, the IUCD programme could be rehabilitated and stabilised in a few States, while in others there is even scope for increasing the rate of adoption. In the conditions prevailing at present, there is not likely to be much shift from one method to the other. The conventional contraceptives can cover a new target group-couples with less than three children who might not be reached by sterilization or IUCD.

The main findings of the investigation are presented below according to the broad objectives of the study:

#### **I. To Study the Problems of Implementation of the Programme, Availability of Services and Their Utilization.**

##### *Organization*

5. The organizational structure had been considerably strengthened particularly at the State and somewhat at the district and block levels in almost all the States. The number of key posts sanctioned during 1967-68 in the State Bureaux varied from 4 to 11 and about three fourths of the sanctioned posts were filled on the specified date.

6. The District Bureaux occupy a key position in the implementation of the programme. In the reorganized programme, the need for a strong team of staff at the district was recognised in order to ensure support, guidance and supervision of the work in the district. In a number of sample districts, not only a small staff was sanctioned but there was also delay in filling the sanctioned posts considering all the sample districts, only two-thirds of the posts sanctioned were filled. Other deficiencies noticed related to turnover of staff, inadequate experience in family planning work and lack of training in family planning.

#### *Integration*

7. Further, the organisational set-up in a number of States had also not been fully streamlined particularly from the point of view of achieving integration of medical, public health and family planning work at the district level. Presently, in most of the States, there is no unified command at the district level under the direction of one single officer in order to utilize to a greater extent available personnel and facilities of these three wings. Perhaps, it would be of advantage if the Chief Medical Officer of the district is made overall incharge.

#### *Staff position at the Family Planning Centres*

8. According to the pattern of staff approved for PHCs, including staff for family planning work, the total number of technical staff would be 21 (this excludes certain categories of staff), of which 13 are borne on the family side. From the analysis of the staff position planning side. From the analysis of the staff position in the sample PHC/F.P. Centres, it was noticed that the total staff was somewhat below the pattern prescribed in a large number of Centres. The average per Family Planning Centre worked out to only 16 i.e., about three-fourths of the total envisaged.

9. The post of the second Medical Officer was still vacant in many of the Primary Health Centres and wherever two doctors were posted, the responsibility given as well as salary, allowances and facilities available to the two doctors were not the same. This differentiation between the two doctors working in the same place should be discontinued and the work of medical, public health and family planning both at the main centre and sub-centre levels, should be equally shared between the two doctors. There is also need to up-grade the services available at the sub-centre level by extending simple medical care through regular visits of the doctor as well as through supply of medical chest to the ANM or to the Panchayat.

10. The staff situation in the Urban Family Planning Centres was generally much better than in the rural centres in terms of the posts filled, experience of the staff in family planning and training status of the staff. The average number of technical staff in the urban centres 4.1 and there was wide variation noticed among the sample centres and it ranged from 1 to 7.

#### *Sub-Centres*

11. The total number of sub-centres before reorganization in the 82 selected PHCs was 177. This worked out to 2.1 sub-centres per PHC. After reorganization, the total number of sub-centres increased to 373 and the average number of sub-centre per PHC was 4.5. The population per sub-centres worked out to 17,000 which is still much above the norm of population fixed for a sub-centre.

#### *Family Planning Work in Medical Institutions*

12. Family Planning work appears to be a weak and an inconspicuous activity in the medical institutions in the urban areas. Large number of deliveries take place in maternity hospitals and centres but the proportion of post-partum cases adopting family planning methods continues to be small. Similarly, a large number of people attend hospitals but there is no regular arrangement to educate and motivate them in family planning methods. This should engage greater attention.

13. There is also the need for close contact and communication between the urban family welfare planning centres and MCH Centres, maternity homes and other hospitals in the urban areas. The attendance at a number of urban family planning centres was found to be not satisfactory and these centres could benefit considerably through such referrals.

14. The family planning programme is not merely a medical or a public health programme but a social action programme which implies influencing the social values of communities, groups and individuals. At present, all the positions at the supervisory levels in the family planning organization are filled by staff from public health and MCH only. On the basis of field observations, it is felt that it will be of great benefit if the experience and skills of the development workers working in fields such as community development, social welfare, panchayats, co-operatives, etc., could be utilised by appointing some of them in supervisory positions in the family planning organisation.

### *Balanced Programme*

15. Although different methods of family planning have been propagated, it has been found that only in a few States, and that also not to a considerable extent, all the three methods, i.e., IUCD, sterilization and conventional contraceptives, have been popularised. The usefulness of the different methods lies in the fact that it would be possible to reach a number of couples who might not yet be ready to accept permanent methods of birth control.

### *Mobile Units*

16. A mobile surgical unit at the rate of one for each district and mobile IUCD unit at the rate of one for every 5 to 7.5 lakhs of population in the district were sanctioned. The mobile units were considered necessary in view of the difficulties in posting qualified staff (surgeons and lady doctors) in the rural PHCs. There had been considerable delay in setting up these mobile units and only in 13 out of 35 sample districts, mobile units were reported. Wherever they were established, they were not fully utilized and their performance could not be considered satisfactory. In view of the fact that there had been under-utilization of mobile units, it would be of advantage if the mobile units could be made multipurpose, attending to vasectomy, IUCD, MCH and Medical care. This would not only make them more popular, but also give greater professional satisfaction to the medical officer.

### *Camps*

17. In a number of States, the camp approach yielded good results especially when they were well-planned and organized. Intensive education-cum-publicity drives generally preceded these camps. The duration of these camps generally varied from 1 to 3 days. While small camps were preferred in Mysore, Gujarat, Maharashtra and Kerala, big camps were organised in Andhra Pradesh and Rajasthan. It was observed that holding of big camps created many problems such as dislocation of work in other institutions, mass feeding programme, transport bottlenecks, lack of accommodation, lack of proper follow-up measures and difficulties in preserving the beds, cots, etc., till the next camp.

18. Camps proved more popular in respect of vasectomy. Over three-fourths of the sample rural Family Planning Centres reported camps for vasectomy in 1967-68. In absolute terms, the achievement was higher as compared to the previous year but in terms of proportion to total accomplishment in the relevant clinics, the achievement in 1967-68 was lower (28.3 %) as compared to the previous year (48 %). The opposite trend was noticed in respect of IUCD both in terms of proportion of Family Planning Centres reporting camps and achievement. In case of tubectomy, only a very few Family Planning Centres reported holding of camps.

### *Visits to PHC/F.P. Centres*

19. The general respondents and opinion leaders had not visited the selected PHCs/F.P. Centres to any significant extent. During the year 1968, only 9 % of the respondents visited the selected PHCs/F.P. Centres as against 12 % during the previous year. More local leaders (17.5 %) seemed to have visited the selected PHC/FPCs during 1968 than during 1967 (8.1 %). Besides the selected centres, a smaller proportion of respondents (5.5 %) reported to have visited other health institutions during 1968. The respondents on an average visited the selected centres 3.3 times during 1968 as against 3.7 times during 1967. The average number of visits for the opinion leaders was higher for both the years as compared to the general respondents. The main purpose of visit to the PHCs was for medical assistance.

### *Field Visits of Staff*

20. The field visits of the staff of the selected family planning centre had not been as wide and frequent as envisaged. Roughly the percentage of villages visited was inversely correlated with the number of visits per village. With the present resources, at the maximum level only about 60 per cent of the villages could be visited with an average minimum of one visit per month. This, of course, varied, somewhat with the different functionaries.

### *Worker's Contact with the Villagers*

21. The peripheral staff are expected to make house to house visits for such purposes as eligible couple survey, follow-up work, education and motivation. About one third of the respondents stated that the Family Planning staff contacted them during 1967-68 as compared to somewhat a lower proportion (22 %) for the previous year. Also, more opinion leaders (local leaders) (57 %) reported to have been contacted in 1968 by the F.P. staff than the general respondents. The Family Planning staff seemed to have contacted different cultural groups also. The percentage figure between groups did not vary much. It ranged from 32 % for Hindus to 26 % in case of Muslims.

22. Once the respondents are aware of the family planning methods and the availability of the services, they are likely to contact the family planning staff for more information and advice before finally deciding to adopt

the method. However, the proportion of respondents contacting any of the Family Planning staff was found to be low (8.7%). Could this be due to their lack of interest or non-availability of the family planning staff in the villages?

#### *Approach*

23. With the present staff-population ratio, it is unrealistic to contact and to motivate all the eligible couples in all the villages in their jurisdiction within a reasonable time. It was noticed that even in villages where no extension effort was reported, there was adoption to a significant extent. This may be attributed to radiating effect of adoption from the adjoining villages as well as to the spread of knowledge of the method and services through informal channels of communication between rural communities. Since it is not possible to organise extension work on an intensive and continuous basis in all villages, it would be a good strategy, perhaps, to concentrate in some selected villages.

#### *Fixation of Targets*

24. Targets were generally broken down to district and block levels mainly on the population basis. Factors such as the availability of services, the staff-population ratio, the nature of terrain, past achievements, etc., were not generally taken into account. Family Planning staff interviewed felt that the fixation of targets on population basis only was not realistic.

#### *Checking of Accomplishments*

25. It was mentioned by a number of State Governments that a random check of 5% of achievement reported was envisaged. But our field officers reported that there was no regular checking of accomplishments at the village level and wherever it was done, it was mainly by nature of checking of records kept at the clinics. In view of the post operative/insertion complications reported and inadequate follow-up a systematic random checking of sterilization and IUCD cases even on a limited scale at various places at regular intervals would go a long way in not only reducing the fictitious reporting, if any, but also lead to early detection of complaints or apprehensions as well to counteract wrong rumours.

26. In this connection, the systematic way by which the field visits of the staff were planned for purposes of motivation of eligible couples and follow-up of adopters at Tiruchirapalli town in Madras State is worth watching and emulating. The Health Officer of the Municipality, recognising the importance of systematic extension and follow-up work at the community level, divided the town Area into a number of blocks and assigned them among ten teams of workers (2 each). The field staff were required to do the field visits in a particular block on the specified day drawn up for the month in advance. Each Block was generally visited twice during the month. During field visits, the workers besides doing follow-up work, attended to motivation of eligible couples as well as collection of data on their knowledge and attitude. Weekly diaries of the workers were submitted regularly and there was a monthly staff meeting to review the work done during the month. The Health Officer, through surprise visits to the area, verified whether the work schedule prescribed for the workers, was followed or not.

#### *Compensation*

27. The payment of compensation to the staff and promoters is found to be an useful adjunct to the programme but it has to be viewed as an *ad-hoc* measure. Experience has shown that in spite of the high incentives offered, progress had been very uneven. The canvasser or the motivator system, though useful for the propagation of the programme, had been given undue importance neglecting extension education. It is for consideration whether the incentive money instead of being given to the individual motivators, may with advantage be given to Panchayat institutions as the amount then could be utilised to meet the welfare needs of the community. This would perhaps encourage the village panchayats to participate more effectively and enthusiastically in the family planning movement.

#### *Training of Staff*

28. For effective implementation of the family planning programme, it is necessary that the staff at all levels concerned with the implementation of the programme, develop the necessary expertise, skills and competence required to carry out efficiently their responsibilities. Therefore, training of personnel should receive high priority.

29. In order to place the field staff in position as expeditiously as possible to meet the programme needs, majority of the staff attended only short orientation courses of 3 to 7 days duration. This would have given them only some knowledge of the programme and perhaps served to remove some of their doubts. In order to strengthen their knowledge and skills, they need to undergo long-term training as early as possible. Besides,

provision is to be made for new elements being added on account of normal wastage due to transfers and retirements. Training Institutes have to design their schedule of work in such a way as to meet the growing demand to ensure sustained efficiency of the programme staff.

30. Due to the sudden expansion of the organisation, Regional Family Planning Training Centres had to be established expeditiously to meet the emergent needs to train a large number of staff. It is understandable, therefore, that in this process, there were difficulties both in regard to the provision for suitable staff, accommodation, arrangement for field work, transport, other facilities, etc. Sooner these deficiencies are removed, the better it is for the efficient working of these institutions.

31. It was observed that the Central Institutes had by and large staff members with adequate background and experience; morale was generally satisfactory with the exception of a few individual members who had experienced difficulties relating to emoluments and facilities offered to them.

32. The Central Training Institutes are required to advise the Regional Family Planning Training Centres in their area on the various training courses organised by them. This function, however, had not yet been exercised effectively.

33. Our discussion with the officials, both administrative and technical, of some States where the progress of the family planning programme has been rather halting, suggests that these States may welcome technical assistance in fields such as training, community organisation and group work, extension education, statistics and demography and programme administration. For this purpose, a scheme may be worked out by which experienced specialists from the Centre and some of the successful States may be deputed for short periods to the other States requiring such services. They should operate as a part of the State organization and work under the supervision of the officer-in-charge of the family planning programme.

## **II. To Review Extension, Education and Achievements**

### *Extension Work in Sample Villages*

34. For the purpose of creating a more receptive atmosphere for the adoption of the family planning programme, the need for using a variety of methods of extension work has been generally recognised. During the year 1967-68, activities such as mass meetings, leaders camps and film shows were reported in 20 to 26% of the sample villages. Group discussions and distribution of pamphlets and posters were reported in over half of the sample villages. There had been more of extension work in the sample villages during 1967-68 as compared to the previous year. This might be partly due to the general improvement in the staff position in 1967-68 as compared to the previous year. In respect of the extension activities, local leaders participated more than the general respondents during both the years. Both participated more during 1967-68 than during 1966-67 in each of the activities.

### *Deficiencies*

35. Whatever programmes in the field of education and communication have been in operation, they have not been fully effective either due to the non-availability of essential equipments and aids or due to insufficient number of extension educators or to the poor quality of extension staff itself. Besides, the community organisation and education at the field level by family planning workers was not as intensive and systematic as was envisaged.

36. Carrying the message of family planning to the village people required the knowledge of the norms and values of the community, individual aspirations and life experiences. The vast majority in the rural or urban areas do not constitute a monolithic group. They are divided into different strata requiring somewhat different types of appeal for the educated, the literates and the illiterates. It is doubtful whether the present family planning messages take care of the needs of the different groups. The script and the situations portrayed in the films and other audiovisual media in most cases do not generally reflect the local milieu.

### *Area of Research*

37. There appear to be differences in the persuasibility of groups and individuals. Also, they respond differently to the various forms of communication. Not enough is known regarding the characteristics of individuals and groups according to levels of persuasibility. This is an area for research.

### *Coordinated Use of Different Methods*

38. There is need for coordinated use of the different methods and channels of mass media, 'personal cosmopolite', and 'personal localite' sources as it would not be possible to influence the attitude and behaviour of the

people through mass media alone. In order to facilitate adoption at the couple level, there appears to be a need for face to face communication to allay misgivings as well as to provide the stimulus and a psychological support to the couples. From this point of view, mass communication and face to face approach should complement each other.

39. In order to get optimum results, the target group should be subjected to prolonged and effective exposure to family planning publicity and education. This is particularly so as couples have exhibited ambivalent attitude towards adoption of specific family planning methods.

40. From the experience gained, it is evident that knowledge and favourable attitude would not by themselves lead to action. There is a gap between awareness and practice of family planning methods. The communication and extension workers should try to identify the social and psychological barriers impeding adoption and design the extension activities accordingly.

#### *Involvement of local leaders*

41. Not much progress has been made in the involvement of village leaders at the local level in supporting the programme. In order that the village leaders may perform the communication functions effectively, they need to be oriented in the methods of family planning and, for this purpose, organisation of camps and discussion groups on a large scale appears to be necessary. Our field observations suggest that the task of involving the so-called opinion leaders in the programme appears to be not difficult as they seem to have greater knowledge, more favourable attitude and hold more progressive views than the general respondents.

42. The fatalistic orientation of the rural people did not appear to have stood in the way of adoption of family planning methods for the purpose of limiting the number of children. This also supports the view-point that human behaviour and action may have both a rational and non-rational orientation. Therefore, new practices could be propagated without modifying directly the existing beliefs and values. This is a pointer to improve programme performances in future.

43. Another favourable trend noticed related to substantial achievement in villages with little or no extension work or the so-called 'backward villages' which were not exposed to communication and other favourable factors. This only points out the importance of informal channels of communication, diffusion of new practices which needs to be exploited to a greater extent than hitherto.

#### *Accomplishment per F.P. Centre*

44. The average accomplishment per family planning centre was generally more for the urban centres as compared to the rural centres for the period 1966-67 for all the methods but this was not so for the year 1967-68. While there was a fall in accomplishment in IUCD both in rural and urban areas, the rise in vasectomy was very considerable in rural centres as compared to the rural centres.

45. Considering the urban areas as a whole (cities and towns), both IUCD and vasectomy programmes received a setback in 1967-68 as compared to the previous year. In contrast to this, tubectomy had become relatively more important in 1967-68. This overall picture was not reflected in towns where the achievement in 1967-68 in vasectomy was much more than the previous year and even higher as compared to cities. Also, there was not setback in 1967-68 in IUCD programme in towns.

46. The urban population had responded more to IUCD than vasectomy as compared to the rural population. Besides, unlike in urban areas, the programme of vasectomy had gained considerable momentum in rural areas in 1967-68 as compared to the previous years.

#### *Accomplishment in the Sample Villages*

47. In the randomly selected sample villages (260) the total accomplishment per thousand population in respect of vasectomy, tubectomy and IUCD since inception of the programme upto 31st March, 1968 was 14. In the purposively selected villages (90) the accomplishment was considerably higher.

#### *Extent of Adoption by Households*

48. Since the accomplishment figures supplied by the staff may not be complete, an attempt was made to collect relevant information from the individual households while listing them for sampling purposes regarding adoption of the three methods of family planning. Out of the total of about 28,000 households with eligible couples listed in the randomly selected villages, the rate of adoption for the different methods was found to be 4.0%



for vasectomy, 2.0% for IUCD and 1.8% for tubectomy. In other words, 7.8% of the households having eligible couples had adopted one of these three methods of family planning in the sample villages. The percentage figure will be somewhat lower if it is related to the total number of couples.

49. Response from the different cultural groups was also encouraging. The rate of adoption of the three methods varied from 8.8% of Hindu households to 5.2% of Muslim households. Response of the different occupation groups to the family planning methods varied somewhat. Vasectomy was most popular among labourers and IUCD and tubectomy among the cultivators.

#### *Adoption by Respondents*

50. Of the 6,005 respondents and 944 local leaders interviewed in all the sample districts, about one-fifth of the general respondents and over one-third (36%) of the local leaders stated to have adopted family planning methods at some time or the other. The extent of adoption was high in districts such as Quilon, Kapurthala, Gansajam, and Mehsana. Of the methods mentioned, the most common was found to be vasectomy and was reported by 8% of the general respondents. Next in importance was found to be 'Condom' and was said to have been adopted by 5.2% of the respondents. The figures for all the above three methods were higher for the opinion leaders. Methods such as abstinence, rhythm and withdrawal were said to have been practised on a limited scale by a small proportion of respondents. This may be partly due to under-reporting of use of these methods.

51. The proportion of respondents in the sample districts using any family planning method at the time of investigation was 11% and in case of local leaders, it was much higher (21%). The IUCD was being used by 2.8% of the respondents only as against 4% ever adopting it. It was observed that opinion leaders as a group were more responsive to the adoption of the family planning programme than the general villagers. This seems to be a healthy trend.

### **III. To Assess the Knowledge, Attitude and Reactions of Adopters and Non-Adopters.**

#### *Knowledge*

52. Three-fourth of the respondents had knowledge of family planning methods as against 91% of local leaders. Large proportion of the respondents (70%) had knowledge of vasectomy. The IUCD was known to 46% of them and tubectomy and Condom to about one-fourth. Local leaders also mentioned these methods but to a larger extent. After probing, a substantial proportion of respondents and local leaders could identify the methods which they did not recollect earlier. Of those who were not practising any family planning method, about half of the general respondents and two-fifths of the local leaders showed willingness to get advice on Family planning.

#### *Communication*

53. In rural communities, communication between individual and groups takes place to a considerable extent through informal channels. Our field investigation showed that person to person communication and discussions relating to family planning were more by local leaders than by the general respondents. Three-fourths of the local leaders reported to have talked to others regarding family planning method, whereas the corresponding figure for the general respondents was only 39%. Majority of the respondents (77%) and local leaders (81%) talked to their friends and neighbours about family planning and the next important group was their spouses. One out of every four respondents also reported that someone in the village had talked to them about the family planning programme during the three months prior to our investigation.

#### *Additional Children Desired*

54. One of the programme goals is to promote the small family norm. Hence the question whether the respondents would like to have more children in addition to what they have would be significant. About half of the respondents (49%) desired to have more children. The proportion of respondents desiring additional children declined at higher orders of living children, more so if there were at least two sons. Thus in case of those with 4 or more children with equal number of boys and girls, 83% of them did not want any more child. Of those desiring children, generally there was a preference for male children.

#### *Reasons for not Desiring more children*

55. The important consideration for not desiring children appeared to be 'financial burden'. This found expression in reasons such as 'had enough children' and was mentioned by 52% of the respondents and 'cannot afford more children' or 'children are expensive', mentioned by about half of the respondents (49%). This might also mean that the norm of the small family was gaining acceptance and their eagerness to raise the living standards. Other reasons such as 'for the sake of wife's health', 'for better care', 'does not like to divide the property', etc., were mentioned only by a small proportion of respondents.

### *Fate Orientation*

56. In order to find out how far the respondents had a rational attitude towards the birth of children they were asked whether the number of children one would have depended on his fate/wish of God. Majority of the respondents (57%) replied in the affirmative. The percentage figure was lower for opinion leaders (37%).

### *Inter-pregnancy Interval*

57. The views of the respondents in respect of spacing between two children is another important index regarding the small family norm. The picture obtained is quite optimistic in that 30% of the respondents favoured an interval 4 to 6 years whereas about half (49%) favoured a period of 2 to 4 years.

### *Sterilization*

58. Majority of the respondents (60%) favoured operation if the couples did not want any more children. A much larger proportion of the local leaders (83%) favoured sterilization. Generally, vasectomy was favoured. As to the time of sterilization, over two-fifths (44%) favoured it after three children, and over one-third (39%) favoured it after the fourth child.

### *Induced Abortion*

59. In recent times, some interest is shown in liberalising abortion under certain circumstances particularly since the rate of illegal abortion has been on the increase. Views of the respondents were ascertained in an indirect way. The opinion leaders held more favourable views towards induced abortion than the general respondents. As against one out of eight general respondents, one out of three opinion leaders supported induced abortion.

### *Source of Information and Motivation*

60. A large number of the adopters of vasectomy from all the three areas, first heard about the programme in 1967 which indicated that perhaps this was the year when intensive family planning drive was launched in a number of States. The picture was different in respect of adopters of other two methods. Data regarding the source of information, decision making, advice given for or against the family planning methods and good or bad things heard, were collected and it appeared that the family planning staff was the most important agent in many respects. Next in importance came friends, husbands and doctors.

### *Good and Bad Things Heard*

61. It is heartening to note that large majority of the adopters reported to have heard good things about the three methods. Here also, the contribution of the family planning staff was extremely significant. All the negative things heard by a large number of adopters related to bad after-effects or that the method was injurious to health. In the case of vasectomy, one-third of those reporting bad things mentioned 'impotency'. Similarly, in the case of IUCD, over one-third reported to have heard that it would cause excessive bleeding. As for the source of information, friends and relatives seemed to play more of a negative role than a positive one as majority of the adopters had heard bad things from them. On the other hand, the adopters of any of the methods seemed to have not played any significant role either by communicating negative or positive information regarding their experiences. This points out the need for making conscious efforts to use friends, neighbours and users of family planning methods for counter-acting rumours and disseminating correct information.

62. It is also significant to note that the overwhelming majority of the respondents were satisfied with the privacy of place. Similarly, there was also satisfaction regarding the behaviour of the doctor and other family planning staff and the time and day of operation. To the question whether operation or insertion was successful in preventing pregnancy, the response obtained was very optimistic. Only a very small percentage replied in the negative.

### *Reactions and after-effects*

63. As regards the physical and psychological reactions that the adopters had experienced after adopting anyone specified family planning method, it was noted that less than half (43%) of the total sampled adopters reported some discomforts or complaints. More adopters of IUCD (about 61%) reported complaints than adopters of other methods. This was uniformly so for the rural, urban and city samples. In the case of vasectomy and tubectomy, the important complaints as mentioned by the adopters related to pain, cramp and general weakness. In the case of IUCD, besides these two, excessive bleeding or prolonged bleeding and white discharge were also reported by a substantial proportion of adopters. Substantial proportion of the complaints were reported to have occurred, by all the categories of adopters, within a period of one month

after the adoption of the method. The complaint also persisted in a large number of cases for more than a year. It is clear, therefore, that there is need for systematic follow-up within a reasonable period after sterilisation or loop insertion in order to identify complaints and to extend necessary treatment and care. With a proper follow up, the length of persistence of complaints also could be substantially reduced. However, the redeeming feature in this not too happy situation was that the majority of adopters having complaints of a severe nature did consult the doctor and the peripheral health staff.

64. Regarding IUCD drop-outs, it was found that removals accounted for about one-third of the total and expulsions about one-fifth. The extent of removals was largely effected by the family planning clinic staff. In contrast to the general impression, very few removals had been done with the help of local da's.

65. Regarding the psychological reactions, the data from both the adopters and their spouses were collected. It is rather heartening to observe that in a majority of cases, the reaction of the spouse was quite favourable. About only one-tenth of the spouses were reported to be unhappy regarding the adoption of vasectomy and IUCD by their spouses. It is, however, a matter of concern that a substantial proportion of the adopters reported adverse after-effects. These were deterioration in the general health standards, decrease in sexual desire or pleasure. Mental anxiety and worry was also reported more in IUCD cases. These reactions were also checked by eliciting the information from the spouses. Though a much smaller proportion of the spouses reported change, the same reactions were confirmed by those reported. This area requires a more thorough investigation of a clinical nature before any positive statement regarding after-effects could be made. However, the fact that more than half in the IUCD and tubectomy cases and more than 80 per cent of the vasectomy cases had not been contacted by the family planning staff, lends some support to the above situation regarding the prevalence of after-effects, assumed or real.

#### IV. To Find Out the Popularity of Different Methods

##### *Motivation for Adoption*

66. The message of family planning from the point of view of national or community interest is not likely to appeal to the people especially from rural areas. Generally, people tend to adopt the family planning methods more for their own interest than for other reasons. However, the prevailing norms and beliefs of the community do affect the couple's attitude towards adoption of the family planning methods. Two factors that seem to affect the pattern of response to the family planning programme are (i) people's concern about infant mortality; and (ii) their dependency on sons during old age. There is also a preference for sons due to religious reasons. It is because of these reasons that a large proportion of couples having three children with more girls than boys, hesitated to limit the number of children to three. Generally, two boys and a total of at least 4 children are desired. This has implication for planning programme goals.

##### *Background of the Adopters*

67. Of the 5708 sampled adopters about one-third of the vasectomy sample, over 85% of the tubectomy sample and about half of the IUCD sample belonged to the urban areas including towns and cities. A large bulk of both the tubectomy and the IUCD sample belonged to the age group 20—40 years, whereas it was 30—50 years in the case of vasectomy sample. Again while in the case of vasectomy, there were more elderly people in the urban areas than in the rural areas, it was the other way round in the case of tubectomy and IUCD sample. The average period of married life for adopters was about 18 years and varied from 19 years in case of couples adopting vasectomy to 16 years for those adopting tubectomy and IUCD. Here also, significant differences were observed between rural and urban areas. The average number of pregnancy per adopting couple varied between 5 and 6 in all the three cases. The difference between the rural and urban areas was more marked in respect of couples adopting tubectomy and IUCD than those adopting vasectomy. It is significant to note that over 60% of the couples adopted either all the three methods only after they had at least three children. In the case of IUCD sample, 44% of women from rural areas had 5 or more children. They seemed to have adopted this method more for the purpose of limiting the family size than for spacing.

68. In general the educational level of husbands of those who adopted tubectomy was higher as compared to others. The response of the different occupational groups varied significantly as between the three methods of family planning. The cultivators' group mainly drawn from the rural areas responded more or less equally to vasectomy and IUCD programmes whereas more labourers had adopted vasectomy as compared to the other two methods. In the case of those in service in cities, the response was highest to the vasectomy programme. Considering the proportion of the cultural groups in the sample areas it appears that the response from all the groups can be considered satisfactory to all the three methods.

69. It is highly interesting to note that substantial proportion of adopters or their husbands both in rural and urban areas had little or no exposure to communication and innovation, such as, education, use of improved seeds and fertilizer for cultivators, use of electricity, reading of newspapers and periodicals etc. Finally, it is also interesting to observe that a large proportion of adopters (88% in case of vasectomy samples to 79% in case of tubectomy samples) had not practised any other method of family planning before. Even those who had practised some methods, use of condom and IUCD were the two important methods mentioned.

70. The field observations have confirmed that during 1967-68, the IUCD programme had suffered a set back. Many family planning staff interviewed seem to attribute the complaints to the device itself. There is perhaps an urgent need to look into the quality of locally produced loops. The field observations also confirm that with pre-insertion check-up and better follow-up service, it may be possible to reduce the complaints to a large extent. For this purpose, a selective approach may be necessary. The IUCD may have to be confined to the specific areas where follow-up work could be done effectively and complaints attended to promptly.

#### *Reasons for Non-adoption*

71. The most important reason given by the general respondents for not adopting any family planning methods was the desire to have more children and was mentioned by 48% of the general respondents and 40% of the local leaders. Lack of knowledge of methods or lack of faith in family planning were mentioned by a substantial proportion of general respondents. Another reason prominently mentioned related to apprehensions about the after-effects.

72. Only half of the persons advised by the adopters seemed to have followed the advice. As for the reasons for not adopting the family planning methods suggested, the important ones were 'apprehensions regarding after-effects' (23%), 'injurious to health' (16%), 'opposition from spouse' (12%) and 'more children desired' (11%).

73. The relative importance of these reasons given by the three categories of adopters differed somewhat. The reasons given for non-adoption confirm that extension of family planning services on a large scale by itself would not lead to adoption of family planning programme. But it should be backed by extension of education organised in a systematic way with a view to overcome apprehensions and prejudices.

74. To sum up, it may be stated that with dedicated and dynamic leadership at all levels, improvement in service, efficient functioning of staff, effective supervision of and guidance to grass root workers, better preparation of the couples and prompt attention in case of complaints, greater involvement of non-officials, addition of new channels of service, concurrent appraisal to find out expeditiously efficiency of the various methods and approaches and better feed-back arrangements, it should be possible to achieve a breakthrough in stabilizing population growth.

#### *Conclusion*

75. The study designed was based on certain hypotheses with a view to giving it a frame of reference/focus. The field data collected and analysed tended to support most of the hypotheses framed. Since these have implications for policy making, they are stated below :

- (a) The desire for a small family is more due to economic reasons than due to change in social norms. This is evident from reasons for adoption of the family planning programme, views on spacing, fatalistic attitude towards number of children etc.
- (b) Adoption of family planning methods could be promoted without changing very much the social norms and values. It was noticed that large proportion of respondents had non-rational attitude in respect of the number of children one might have. In spite of this, they had adopted vasectomy or IUCD. This shows that human behaviour may have both a rational and non-rational orientation. Therefore, new practices could be propagated without modifying directly the existing beliefs and values. This is a pointer to improve programme performance.
- (c) Friends, relatives and local leaders play an important role in creating the climate for wider acceptance of the programme. This only emphasizes the importance of the informal channels of communication in spread of new practices and was fully borne out by this study. Substantial achievement was reported in sample villages with very little or no extension work.
- (d) The contact of the family planning staff with the local community leaders and organizations, if limited is likely to affect the progress of the programme to a significant extent. It was noticed that the family planning Staff has more contact with the community leaders than with the general respondents. But their

contact with local organizations, and interested groups such as Panchayats, Cooperatives, Youth Clubs, Mahila Mandals etc. appeared to be not as intimate as one would expect. With the data collected, it was not possible to come to any firm conclusion as to how far this had affected the programme acceptance. This needs a deeper probe.

- (e) Response from the people to sterilisation or IUCD programme would be greater from higher age groups than from the lower age and parity groups. This is evident from the analysis of the age group of the adopters of IUCD and sterilisation. More couples in the higher parity group had responded to the programme than others.
- (f) People are likely to have feelings of ambivalence about family planning. Therefore, the programme of education and communication should be carried out on a continuous basis in order to overcome this tendency. This is supported by the fact that some of the adopters had postponed the operations/IUCD insertions for some reason or the other. Also, it was noted that the villagers were exposed to both negative and positive information regarding the different family planning methods. One of the important reasons given by the adopters for others not following their advice was said to be apprehensions and fear of consequences. Therefore, it is not surprising that analysis of achievement over a three year period at the village or block levels showed significant rise and fall.



**Annexure—C**

*Evaluation of the Family Planning Programme—List of States/Districts/PHCs/Villages Covered by the Study*

Sl. No.	States	Districts	PHCs	Villages
1	2	3	4	5
1.	Andhra Pradesh	1. West Godavari (P)	1. Yendagandi (P)	1. Kondapadu (N)
			2. Kamavarapukota (NP)	2. Panduvva (F)
		2. Medak	3. Pullur (P)	3. Guntupalli (N)
			4. Pulkal (NP)	4. Makkinavarigudem (F)
				5. Ramancha (N)
				6. Ghanpur (F)
				7. Pocharam (N)
				8. Kansanpally (F)
2.	Bihar	3. Patna (P)	5. Patna Sadar (P)	9. Mainpura (N)
			6. Barh (NP)	10. Punadih (F)
		4. West Champaran (NP)	7. Betiah (P)	11. Ranabigha (N)
			8. Majhanlia (NP)	12. Kalyanpur (F)
				13. Barwat-Sena (N)
				14. Pipara Pakar (F)
				15. Bhanachak (N)
				16. Amawamajhar (F)
3.	Gujarat	5. Kheda (P)	9. Kathana (P)	17. Divel (N)
			10. Virpur (NP)	18. Sarole (F)
		6. Kutch (NP)	11. Darsadi (P)	19. Varadhara (N)
			12. Dhaneti (NP)	20. Bhanthala (F)
				21. Khojachora (N)
				22. Rayan Moti (F)
				23. Padhar (N)
				24. Tharavdanana (F)
4.	Haryana	7. Rohtak (P)	13. Sampla (P)	25. Garhi Sampla (N)
			14. Chhara (NP)	26. Kheri-Jassor (F)
		8. Ambala (NP)	15. Raipurani (P)	27. Kharar (N)
				28. Nayagaon (F)
				29. Garhi (N)
				30. Dhanana (F)

1	2	3	4	5
			16. Khizrabad (NP)	31. Khizrabad (N)
				32. Kharwan (F)
5. Himachal Pradesh	9. Hamirpur (P)		17. Bhota (P)	33. Mansui-Chhorab (N)
			18. Bhoranji (NP)	34. Dhameri (F)
				35. Balag (N)
				36. Badechar (F)
	10. Sirmur (NP)		19. Dhagera (P)	37. Kaulawala-Bhood (N)
			20. Shillai (NP)	38. Aulawali-Kotari (F)
6. Jammu & Kashmir	11. Srinagar/Budgam (P)		21. Budgam (P)	39. Shillai (N)
			22. Khansahib (NP)	40. Ronahut (F)
				41. Ichgam (N)
				42. Sholipora (F)
	12. Kathua (NP)		23. Parole (P)	43. Krishpora (N)
			24. Hiranagar (NP)	44. Kremshore (F)
7. Karnataka	13. Mandya (P)		25. Kodyala (P)	45. Jakhbare (N)
			26. Akkihebbal (NP)	46. Buddhi (F)
				47. Bhaiya (N)
	14. Gulbarga (NP)		27. Dornahalli (P)	48. Rajpora (F)
			28. Kollur (NP)	49. Thadagavadi (N)
8. Kerala	15. Trivandrum (P)		29. Vellanad (P)	50. Chandagala (F)
			30. Kallara (NP)	51. Voddara Gudi (N)
	16. Palghat (NP)		31. Alanallur (P)	52. Hereganahalli (F)
			32. Koduvayur (NP)	53. Gundalli (N)
9. Madhya Pradesh	17. Indore (P)		33. Hatod (P)	54. Chamanal (F)
			34. Depalpur (NP)	55. Tharkashpet (N)
				56. Ramthirth (F)
				57. Velland (N)
				58. Vidura (F)
				59. Kallara (N)
				60. Peringamala (F)
				61. Alannalur West (N)
				62. Pottassery (F)
				63. Koduvayur (N)
				64. Elvancherry (F)
				65. Budaniya (N)
				66. Pedmi (F)
				67. Bardihoz (N)
				68. Kalibillod (F)

1	2	3	4	5
		18. Rewa (NP)	35. Theother (P)	69. Duara (N)
				70. Padri (F)
			36. Naigarhi (NP)	71. Barroha (N)
				72. Akovri (F)
10. Maharashtra	19. Amravati (P)	37. Daryapur (P)		73. Pethitbadpur (N)
		38. Teosa (NP)		74. Sawanga (BK) (F)
	20. Parbhani (NP)	39. Akhadabalapur (P)		75. Shendur Jana Bazar (N)
		40. Rampuri (NP)		76. Marda (F)
				77. Kupti (N)
				78. Sindgi (F)
11. Orissa	21. Phulbani (NP)	41. Gresingia (P)		79. Sarangapur (N)
		42. Dharangbadi (NP)		80. Dhalegaon (F)
				81. Dugudi (N)
				82. Khariapada (F)
				83. Greenbadi (N)
				84. Tilory (F)
12. Punjab	22. Ropar (P)	43. Nurpur Bedi (P)		85. Sainy Majra (N)
		44. Kiratpur (NP)		86. Tibataprian (F)
				87. Kiratpur (N)
				88. Bhallari (F)
	23. Faridkot (NP)	45. Chaksherewala (P)		89. Mahanbadhar (N)
		46. Panjgurainkalan (NP)		90. Maur (F)
				91. Gharianwala (N)
				92. Waradapaka (F)
13. Rajasthan	24. Sriganganagar (P)	47. Sadul Sahar (P)		93. Takha/hazare (N)
		48. Chhanibari (NP)		94. Sant Pura (F)
				95. Savai Chhani (N)
				96. Sikrori (F)
	25. Barmar (NP)	49. Baktu (P)		97. Madpura-Barwala (N)
		50. Ramsar (NP)		98. Kharapar (F)
				99. Ramsar (N)
				100. Siyani (F)
14. Tamil Nadu	26. Madurai (P)	51. Chinnalapatti (P)		101. Ambathurai (N)
		52. Mannavanur (NP)		102. Pithalaipatti (F)
				103. Poondi (N)
				104. Villapatti (F)
	27. Ramnad (NP)	53. Pandalagudi (P)		105. Pandalagudi (N)
				106. Kurundamadam (F)



1	2	3	4	5
			54. Peraiyur (NP)	107. Peraiyur (N)
				108. Keelaramanadhi (F)
15. Uttar Pradesh	28. Naimital (P)		55. Kela Khera (P)	109. Ramnagar (N)
			56. Kota Bagh (NP)	110. Haripura-Harsan (F)
	29. Lakhimpur-Kheri (NP)		57. Pallia (P)	111. Awalakot (N)
			58. Isha Nagar (NP)	112. Bajunia-Haldu (F)
				113. Bansi Nagar (N)
				114. Bisen Puri (F)
16. West Bengal	30. Nadia (P)		59. Bethna-Dabari (P)	115. Nagaria (N)
			60. Bagula (NP)	116. Lakhun (F)
	31. Howrah (NP)		61. Amta-I (P)	117. Jagadanandapur (N)
			62. Brindabanpur (NP)	118. Dadupur (F)
				119. Bagula (N)
				120. Itaberia (F)
				121. Dakshin-Harishpur (N)
				122. Kurit (F)
				123. Basudevpur (N)
				124. Burikhali West (F)
16	P=15; NP=16; T=31		P=30; NP=32; T=62	N=60; F=64; T=124
P = Progressive;	NP = Non-progressive;			T = Total;
N = Nearest;	F = Farthest			

**Annexure—D**

*Organisational Chart of the Family Planning Programme*

**CENTRAL LEVEL**

Government of India  
*Ministry of Health and Family Welfare*  
*(Department of Family Welfare)*

**STATE LEVEL**

*(Department of Health and Family Welfare)*  
*(Directorate of Family Welfare)*

*State Family Welfare Cell*

*State Family Welfare Bureau*

**DISTRICT LEVEL**

*District Family Welfare Bureau*

**BLOCK LEVEL**

*Primary Health Centre (PHC)*  
*(Rural Family Welfare Centre)*

*Sub-Centre*

**Annexure--E**

**Organisational Set-up of State Family Welfare Bureaux**

**State Family Welfare Bureau**

(Under Directorate of Family Welfare)

**ADDITIONAL/JOINT/DEPUTY DIRECTOR (FW)**

**ADMINISTRATION  
&  
ACCOUNTS**

**TECHNICAL DIVISIONS**

Education and Information Division	Operational and Planning Division	Training Division	Demographic and Evaluation Cell
1. Miss Education and Infor- mation Officer	1. Deputy/Assistant Director	1. Assistant Director	1. Demographer
2. Health Education Officer	2. Other Supporting Staff	2. Other Supporting Staff	2. Social Scientist
3. Exhibition/Outdoor Publicity Audiovisual Officer			3. Statistician
4. Other Supporting Staff			4. Statistical Assistant
			5. Statistical Investigator
			6. Family Welfare Field and Evaluation Worker
			7. Other Supporting Staff

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## Appendix table - 2.1

Technical Staff Sanctioned and in Position at the State Level in the Selected States (as on 31-3-1983).

State	Category of Technical Staff (Designation)																		
	Additional family welfare Commissioner	Director	P	S	P	S	P	Additional Director	Joint Director	Deputy Director	Assistant Director	Mass Education & Information Officer	Health Education Officer	Exhibition/Outdoor Publicity Audiovisual officer					
	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	
1. Andhra Pradesh	.	.	.	1	1	1						1	1	1					
2. Bihar	.	.	.		1	1			3	2				1	1	1	1	1	
3. Gujarat	.	.	.	.	.	.			1	1	1	1	1*	1*	1	1	2	..	
4. Haryana	.	.	.	.	.	.					2	2	1@	1@	1	1	2	2	
5. Himachal Pradesh	.	.	.	.	.	.			3	3	5	5	1	1			1	1	
6. Jammu & Kashmir	.	.	.	.	.	.			1	1	2	2	1	1			1	1	
7. Karnataka	.	.	.	.	1	1			4	4			1@	1@	1*	1*	1	1	
8. Kerala	.	.	.	.	1	1							1	1	1	1			
9. Madhya Pradesh	.	.	.	1	1				2	2			1	1	1	1	1	1	
10. Maharashtra	.	.	1	1			1	1	9	9	8	8		1	1	1	1@	1@	
11. Orissa	.	.	.	1	1				5	5				1	1				
12. Punjab	.	.	.	.	.		1	1			3	3	1	1					
13. Rajasthan	.	.	.	.	1	1			1	1	1	1	1*	1*	1	1	2	1	
14. Tamil Nadu	.	.	.	.	.	.			1	1	3	3	2	2	1	..			
15. Uttar Pradesh	.	.	.	.	1	1	1	1	1	1			1	1	1*	1*	1*	1*	
16. West Bengal	.	.	.	.	.	1	1				2	2	1	1	1	1	1	1	
TOTAL	.	.	1	1	4	6	5	5	31	30	27	27	14	14	13	12	14	11	

Appendix table 2.1 (Contd.)

State	Category of Technical Staff (Designation)																Family Welfare Field and Evaluation Worker				Total	
	Demographer		Social Scientists		Statistical Officer/ Statistician		Statistical Investigator		Statistical Assistant		Family Welfare Field and Evaluation Worker		Total		Family Welfare Field and Evaluation Worker		Total		Family Welfare Field and Evaluation Worker		Total	
	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P
1	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41
1. Andhra Pradesh	1	1	1	1	1	1	1	1	1	1	10	1	19	9								
2. Bihar	1	1	1	1	1	1	1	1	1	1			11	10								
3. Gujarat	1	1	1	1	2	2	1	1	1	1	9	9	21	18								
4. Haryana	1*	1*											8	8								
5. Himachal Pradesh					2	2			2	2			15	15								
6. Jammu & Kashmir	1	1	1	1	1	1	1	1	1	1	3	3	12	10								
7. Karnataka	1	1	1	1	2	2			2@	2@			14	14								
8. Kerala	1	1	1	1	1	1	4	4	1	1	1	1	10	10								
9. Madhya Pradesh	1	1	1	1	2	2	1	1	1	1	14	14	26	25								
10. Maharashtra	1	1	1	1	2	2	1	1	1	1			26	26								
11. Orissa			1*	1*	2*	2*	1	1	1	1	4	2	16	13								
12. Punjab	1	1	1	1	2	2							9	8								
13. Rajasthan			1*	1*	2	2	11	11	3	3			24	23								
14. Tamil Nadu	1	1			1	1	1	1	1	1	7	7	18	17								
15. Uttar Pradesh	1	1	1	1	1	1							9	9								
16. West Bengal	1	1	1	1	2	2	1	1	1	1			12	12								
TOTAL	13	12	12	9	23	23	24	23	15	13	48	37	250	227								

S = No. sanctioned

P = No. in position

\*Designated as Assistant Director

@Designated as Deputy Director

£One post designated as Deputy Director

Appendix Table 2.2

Technical Staff Sanctioned and in Position at the State Level in the Selected States (as on 31-3-83)—Consolidated Position

Category of Staff (Designation)	No. Sanctioned	No. in Position	Percentage (Col. 3 & Col.2)
1	2	3	4
1. Additional Family Welfare Commissioner/Director/Additional Director/Joint Director/Deputy Director (Incharge of F.P. Programme)	16	16	100.0
2. Additional Director	1	1	100.0
3. Joint Director	2	2	100.0
4. Deputy Director	28	27	96.4
5. Assistant Director	27	27	100.0
6. Mass Education and Information Officer	14	14	100.0
7. Health Education Officer	13	12	92.3
8. Exhibition/Out-door Publicity/Audio-visual Officer	14	11	78.6
9. Demographer	13	12	92.3
10. Social Scientist	12	9	75.0
11. Statistical Officer/Statistician	23	23	100.0
12. Statistical Investigator	24	23	95.8
13. Statistical Assistant	15	13	86.7
14. Family Welfare Field and Evaluation Worker	48	37	77.1
TOTAL	250	227	90.8



**Appendix Table 2.3**  
**Technical Staff Sanctioned and in Position at District Level in the Selected Districts**  
 (as on 31st March, 1983)

State	No. of Districts selected	No. of Districts Reporting	Category of Technical Staff (Designation)															Total
			District Family Welfare Officer			District Mass Education and Media Officer			District Extension Educator			Statistical Investigator/ Assistant			Family welfare field and evaluation worker			
			S	P		S	P		S	P		S	P		S	P		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
1. Andhra Pradesh	.	2	2	2	2	2	4	3	2	2	—	—	10	9				
2. Bihar	.	2	2	2	2	2	—	—	2	—	1	1	7	5				
3. Gujarat	.	2	2	2	2	1	4	4	2	2	—	—	10	9				
4. Haryana	.	2	2	2	2	1	4	4	2	2	—	—	10	9				
5. Himachal Pradesh	.	2	2	2	2	—	4	—	2	1	—	—	10	3				
6. Jammu & Kashmir	.	2	1	1	1	1	1	1	1	1	—	—	4	4				
7. Karnataka	.	2	2	1	4**	4**	2	1	2	2	—	—	10	8				
8. Kerala	.	2	2	2	6	5	2	1	1	1	3	1	14	9				
9. Madhya Pradesh	.	2	1	1	2+	3+	—	—	1	1	—	—	5	5				
10. Maharashtra	.	2	2*	2*	2	2	2	2	2	2	1	1	9	9				
11. Orissa	.	1	1	1	3+	2+	—	—	1	1	—	—	5	4				
12. Punjab	.	2	2	1	6	6	—	—	2	2	—	—	10	9				
13. Rajasthan	.	2	2	2	2	1	—	—	2	1	—	—	6	4				
14. Tamil Nadu	.	2	1	1	1	1	—	—	1	1	—	—	3	3				
15. Uttar Pradesh	.	2	2@	2@	2	2	3	3	3	3	—	—	10	10				
16. West Bengal	.	2	1	1	2	2	—	—	1	1	1	1	5	5				
TOTAL	.	31	27	25	42	35	26	18	27	23	6	4	128	105				

S=No. Sanctioned

P=No. in Position

\*In addition, there were 2 Additional Health Officer in each of the districts.

@B-sides the Chief Medical Officer there were 3 posts of Dy. C.M.O. in each district.

\*\*Two Dy. District Education Officers (one male and one female) looking after Mass Media in each of the district.

‡Includes 4 posts (2 each for a district) of Dy. M.E.I.O.

\$In addition to Mass Education &amp; Information Officer there are the Deputy M.E.I.O. in each district.

+Includes 2 posts of Dy. M.E.I.O.

Appendix Table 2.4  
*Technical Staff Sanctioned and in Position in the Selected Primary Health Centres (as on 31-3-1983)*

State	No. of Selected PHCs	Medical Officer			Block Extension Educator			Lady Health Visitor/ Supervisor			Auxiliary Nurse and Midwife			Family Welfare Health Assistant			Multipurpose worker			Computer			Total		
		S	P	P	S	P	P	S	P	P	S	P	P	S	P	P	S	P	P	S	P	P	S	P	P
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18								
1. Andhra Pradesh . . . . .	4	4	4	4	4	6	31	31	—	—	—	27	27	4	4	76	76(100.0)								
2. Bihar . . . . .	4	4	4	4	4	4	3	17	17	—	—	12	12	4	4	45	44(97.8)								
3. Gujarat . . . . .	4	4	4	4	4	19	18	52	46	—	—	87	86	4	4	170	162(95.3)								
4. Haryana . . . . .	4	4	4	4	4	7	5	36	35	—	—	18	16	4	4	73	68(93.2)								
5. Himachal Pradesh . . . . .	4	4	4	4	3	2	2	10	10	—	—	—	—	4	4	24	23(95.8)								
6. Jammu & Kashmir . . . . .	4	4	3	4	4	1	—	8	8	—	—	8	8	—	—	25	23(92.0)								
7. Karnataka . . . . .	4	4	2	4	4	14	13	48	45	—	—	45	30	2	2	117	96(82.1)								
8. Kerala . . . . .	4	4	4	4	4	9	6	55	52	25	24	—	—	2	2	99	92(92.9)								
9. Madhya Pradesh . . . . .	4	5*	4	4	4	7	7	36	18	8	8	41	41	4	4	105	86(81.9)								
10. Maharashtra . . . . .	4	4	4	4	4	3	5	2	34	33	4	4	—	2	2	53	48(90.6)								
11. Orissa . . . . .	2	2	2	2	2	2	2	3	2	3	3	17	14	2	2	31	27(87.1)								
12. Punjab . . . . .	4	4	3	4	3	4	4	20	19	—	—	16	11	4	4	52	44(84.6)								
13. Rajasthan . . . . .	4	4	4	4	2	4	2	20	9	16	9	—	—	4	2	52	28(53.8)								
14. Tamil Nadu . . . . .	4	4	3	4	3	5	5	4	4	1	1	—	—	4	4	22	20(90.9)								
15. Uttar Pradesh . . . . .	4	4	4	3@	3@	27	17	33	24	6	6	96x	40x	1	1	170	95(55.9)								
16. West Bengal . . . . .	4	4	4	4	6	4	5	33	24	29	27	3	3	3	3	84	70(83.3)								
TOTAL . . . . .	62	63	57	63	55	122	97	440	377	92	82	370	288	48	46	1198	1002								
			(90.5)		(87.3)	(79.5)		(85.7)		(89.1)		(77.8)		(95.0)			(83.6)								

(Percentages in parenthesis)

S = No. sanctioned.

P = No. in position.

\* = 2 posts of Medical officer sanctioned for F.W. work in one of the selected PHCs.

@ = In one newly started PHC no such post yet sanctioned.

x = In two PHCs sanctioned strength is two.

x-1 includes posts of AN MS of one district.

Appendix Table 2.5

Technical Staff at the State Level Trained in Family Welfare (as on 31-3-83)

Category of Staff (Designation)	No. in position	Training status not available	Training in Family Welfare		Percentage (Col. 5 & Col. 4)
			No. reporting	No. trained	
1	2	3	4	5	6
1 Additional Family Welfare Commissioner/Director/Additional Director/Joint Director/Deputy Director (Incharge of Family Planning Programme)	16	2	14	14	100.0
2 Additional Director	1	1	Nil	..	..
3 Joint Director	2	2	Nil	..	..
4 Deputy Director	27	11	16	15	93.8
5 Assistant Director	27	13	14	14	100.0
6 Mass Education and Information Officer	14	3	11	11	100.0
7 Health Education Officer	12	2	10	9	90.0
8 Exhibition/Out-door Publicity/Audio-Visual Officer	11	2	9	7	77.8
9 Demographer	12	3	9	8	88.9
10 Social Scientist	9	3	6	4	66.7
11 Statistical Officer/Statistician	23	6	17	10	58.8
12 Statistical Investigator	23	2	21	19	90.5
13 Statistical Assistant	13	1	12	6	50.0
14 Family Welfare Field and Evaluation Worker	37	4	33	19	57.6
Total	227	55	172	136	79.1

Appendix Table 3.1

Distribution of Selected Villages by Distance of the Availability of Health/Medical Facilities.

Facilities	No. of villages reporting facilities by distance							Total No. of villages
	In the village No. (%)	Within less than 5 kms. No. (%)	5-10 kms. No. (%)	10-15 kms. No. (%)	15-25 kms. No. (%)	25 kms. and above No. (%)	Villages not reporting No. (%)	
1	2	3	4	5	6	7	8	9
<b>1 Hospital – Govt./Local Bodies/Private</b>								
(i) Progressive districts	6(10.0)	16(26.7)	11(18.3)	11(18.3)	6(10.0)	8(13.3)	2(3.3)	60
(ii) Non-progressive districts	4(6.2)	12(18.8)	16(25.0)	11(17.2)	6(9.4)	15(23.4)	..	64
(iii) Total	10(8.1)	28(22.6)	27(21.8)	22(17.7)	12(9.7)	23(18.5)	2(1.6)	124
<b>2 Dispensary – Govt./Local Bodies/Private</b>								
(i) Progressive districts	11(18.3)	27(45.0)	8(13.3)	4(6.7)	2(3.3)	2(3.3)	6(10.0)	60
(ii) Non-progressive districts	12(18.8)	16(25.0)	19(29.7)	4(6.2)	8(12.5)	2(3.1)	3(4.7)	64
(iii) Total	23(18.5)	43(34.7)	27(21.8)	8(6.5)	10(8.1)	4(3.2)	9(7.2)	124
<b>3 Private Practitioner</b>								
(i) Progressive districts	36(60.0)	15(25.0)	6(10.0)	2(3.3)	..	..	1(1.7)	60
(ii) Non-progressive districts	30(46.9)	9(14.1)	11(17.2)	3(4.7)	3(4.7)	2(3.1)	6(9.4)	64
(iii) Total	66(53.2)	24(19.4)	17(13.7)	5(4.0)	3(2.4)	2(1.6)	7(5.6)	124
<b>4 Trained Midwife/Dai</b>								
(i) Progressive districts	46(76.7)	8(13.3)	1(1.7)	1(1.7)	..	1(1.7)	3(5.0)	60
(ii) Non-progressive districts	35(54.7)	10(15.6)	12(18.7)	3(4.7)	1(1.6)	..	3(4.7)	64
(iii) Total	81(65.3)	18(14.5)	13(10.5)	4(3.2)	1(0.8)	1(0.8)	6(4.8)	124

N. B : – Figures in brackets are percentages. All percentages are in respect of col. 9.

**Appendix Table-4.1**  
*Distribution of Villages by Frequency of Extension Efforts Made*

Extension method and frequency per year	1980-81 No.	(%)	1981-82 No.	(%)	1982-83 No.	(%)
1	2		3		4	
<b>1. Films show</b>	(N=35)		(N=40)		(N=20)	
(i) Once . . . . .	20	(57.2)	23	(57.5)	11	(55.0)
(ii) Twice . . . . .	11	(31.4)	10	(25.0)	7	(35.0)
(iii) Thrice & Four Times . . . . .	2	(5.7)	5	(12.5)	1	(5.1)
(iv) Five times or more . . . . .	2	(5.7)	2	(5.0)	1	(5.0)
<b>2. Group meetings</b>	(N=95)		(N=99)		(N=101)	
(i) Less than 3 . . . . .	11	(11.6)	7	(7.1)	14	(18.9)
(ii) 3 to 6 times . . . . .	19	(20.0)	21	(21.2)	19	(18.8)
(iii) 7 to 12 times . . . . .	23	(24.2)	20	(20.2)	25	(24.7)
(iv) More than 12 times . . . . .	42	(44.2)	51	(51.5)	43	(42.6)
<b>3. Mass meetings</b>	(N=45)		(N=51)		(N=46)	
(i) Once . . . . .	24	(53.3)	27	(52.9)	26	(56.5)
(ii) Twice . . . . .	10	(22.2)	11	(21.6)	6	(13.0)
(iii) Thrice & Four times . . . . .	4	(8.9)	4	(7.8)	5	(10.9)
(iv) Five times or more . . . . .	7	(15.6)	9	(17.7)	9	(19.6)
<b>4. Family Planning Camps</b>	(N=47)		(N=50)		(N=43)	
(i) Once . . . . .	21	(44.7)	20	(40.0)	23	(53.5)
(ii) Twice . . . . .	13	(27.7)	13	(26.0)	7	(16.3)
(iii) Thrice & Four times . . . . .	5	(10.6)	9	(18.0)	6	(13.9)
(iv) Five times or more . . . . .	8	(17.0)	8	(16.0)	7	(16.3)
<b>5. Exhibition</b>	(N=14)		(N=16)		(N=12)	
(i) Once . . . . .	10	(71.4)	13	(81.2)	9	(75.0)
(ii) Twice . . . . .	3	(21.4)	3	(18.8)	3	(25.0)
(iii) Thrice & Four times . . . . .	1	(7.2)	Nil	(0.0)	Nil	(0.0)
(iv) Five times or more . . . . .	Nil	(0.0)	Nil	(0.0)	Nil	(0.0)
<b>6. Posters displayed</b>	(N=97)		(N=94)		(N=93)	
(i) Upto 12 . . . . .	43	(44.3)	94	(100.0)	93	(100.0)
(ii) 13 to 25 . . . . .	23	(23.7)	Nil	(0.0)	Nil	(0.0)
(iii) 26 to 50 . . . . .	21	(21.7)	Nil	(0.0)	Nil	(0.0)
(iv) 51 and more . . . . .	10	(10.3)	Nil	(0.0)	Nil	(0.0)
<b>7. Pamphlets distributed</b>	(N=97)		(N=98)		(N=102)	
(i) Upto 25 . . . . .	35	(36.1)	98	(100.0)	102	(100.0)
(ii) 26 to 50 . . . . .	27	(27.8)	Nil	(0.0)	Nil	(0.0)
(iii) 51 to 100 . . . . .	17	(17.5)	Nil	(0.0)	Nil	(0.0)
(iv) 101 and above . . . . .	18	(18.6)	Nil	(0.0)	Nil	(0.0)

N.B. :- Figures in brackets are percentages.

**Appendix Table - 4. 2**  
*Distribution of Villages by Average Attendance of Villagers*

Extension Method/frequency of attendance		1980-81 No. (%)	1981-82 No. (%)	1982-83 No. (%)
1	2	3	4	
<b>1. Film shows</b>	(N=35)	(N=40)	(N=20)	
(i) Upto 20	0 (0.0)	1 (2.5)	0 (0.0)	
(ii) 21 to 50	1 (2.9)	1 (2.5)	0 (0.0)	
(iii) 51 to 100	4 (11.4)	6 (15.0)	3 (15.0)	
(iv) 101 and more	30 (85.7)	32 (80.0)	17 (85.0)	
<b>2. Group Meetings</b>	(N=95)	(N=99)	(N=101)	
(i) Upto 10	34 (35.8)	37 (37.4)	34 (33.7)	
(ii) 11 to 20	27 (28.4)	29 (29.3)	27 (26.7)	
(iii) 21 to 50	25 (26.3)	22 (22.2)	28 (27.7)	
(iv) 51 to 100	9 (9.5)	11 (11.1)	12 (11.9)	
(v) 101 and more	0 (0.0)	0 (0.0)	0 (0.0)	
<b>3. Family Planning Camps</b>	(N=47)	(N=50)	(N=43)	
(i) Upto 10	15 (31.9)	17 (34.0)	15 (34.9)	
(ii) 11 to 20	10 (21.3)	7 (14.0)	4 (9.3)	
(iii) 21 to 50	14 (29.8)	16 (32.0)	17 (39.5)	
(iv) 51 to 100	5 (10.6)	5 (10.0)	5 (11.6)	
(v) 101 and more	3 (6.4)	5 (10.0)	2 (4.7)	
<b>4. Exhibition</b>	(N=14)	(N=16)	(N=12)	
(i) Upto 20	0 (0.0)	1 (6.2)	2 (16.7)	
(ii) 21 to 50	6 (42.9)	6 (37.5)	4 (33.3)	
(iii) 51 to 100	2 (14.3)	6 (37.5)	3 (25.0)	
(iv) 101 and more	6 (42.9)	3 (18.8)	3 (25.0)	

N.B.:- Figures in brackets are percentages.

Appendix Table—4.3

Distribution of Sample Households by Number of Mass Media in Contact With

Type of district	Category of respondents	No. of respondents	Respondents reporting contact		Percentage of respondents reporting contact with		
			No.	Percentage	One medium	Two media	Three media
1	2	3	4	5	6	7	8
<i>Progressive</i>							
	(i) Adopters . . . . .	523	484	92.5	21.3	34.5	44.2
	(ii) Non-adopters . . . . .	294	271	92.2	25.8	37.6	36.5
	Total	817	755	92.4	22.9	35.6	41.5
<i>Non-Progressive</i>							
	(i) Adopters . . . . .	501	419	83.6	27.7	33.7	38.7
	(ii) Non-adopters . . . . .	312	266	85.3	37.6	27.1	35.3
	Total	813	685	84.3	31.5	31.1	37.4
<i>All Districts</i>							
	(i) Adopters . . . . .	1024	903	88.2	24.3	34.1	41.6
	(ii) Non-adopters . . . . .	606	537	88.6	31.7	32.4	35.9
	Total . . . . .	1630	1440	88.3	27.0	33.5	39.5

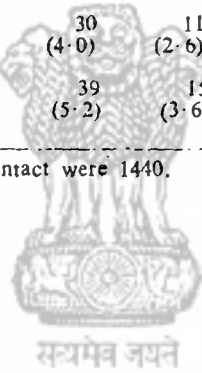
Appendix Table- 4.4

## Distribution of Sample Households Reporting Contact by Type of Mass Media

Type of mass media	No. reporting contact with mass media								
	Progressive districts			Non-progressive districts			All districts		
	Adopters	Non-adopters	Total	Adopters	Non-adopters	Total	Adopters	Non-adopters	Total
1	2	3	4	5	6	7	8	9	10
1. Radio/Transistor . . . . .	399 (82.4)	222 (81.9)	621 (82.3)	350 (83.5)	206 (77.4)	556 (81.2)	749 (82.9)	428 (79.7)	1177 (81.7)
2. Cinema/Films . . . . .	226 (46.7)	108 (39.9)	334 (44.2)	191 (45.6)	113 (42.5)	304 (44.4)	417 (46.2)	221 (41.2)	638 (44.3)
3. News/Papers . . . . .	180 (37.2)	71 (26.2)	251 (33.2)	159 (37.9)	82 (30.8)	241 (35.2)	339 (37.5)	153 (28.5)	492 (34.2)
4. Hoardings/Posters . . . . .	182 (37.6)	123 (45.4)	305 (40.4)	108 (25.8)	78 (29.3)	186 (27.2)	290 (32.1)	201 (37.4)	491 (34.1)
5. Pamphlets/Folders . . . . .	41 (8.5)	22 (8.1)	63 (8.3)	46 (11.0)	26 (9.8)	72 (10.5)	87 (9.6)	48 (8.9)	135 (9.4)
6. Television . . . . .	25 (5.2)	5 (1.8)	30 (4.0)	11 (2.6)	8 (3.0)	19 (2.8)	36 (4.0)	13 (2.4)	49 (3.4)
7. Others . . . . .	20 (4.1)	19 (7.0)	39 (5.2)	15 (3.6)	13 (4.9)	28 (4.1)	35 (3.9)	32 (6.0)	67 (4.7)

N.B. 1.—1. Total no. of respondents reporting contact were 1440.

2. Figures in brackets are percentages.





Appendix Table-4.5

Statewise Distribution of Sample Households Reporting Contact by Type of Mass Media

State	No. of Respondents reporting contact	No. of Respondents reporting contact with Mass Media								
		Radio/Transistor			Cinema			News Paper		
		Adopters	Non-Adopters	Total	Adopters	Non-Adopters	Total	Adopters	Non-Adopters	Total
1	2	3	4	5	6	7	8	9	10	11
1. Andhra Pradesh	73	38	32	70 (95.9)	25	12	37 (50.7)	5	3	8 (11.0)
2. Bihar . .	120	73	37	110 (91.7)	33	12	45 (37.5)	31	9	40 (33.3)
3. Gujarat . .	69	35	15	50 (72.5)	—	—	—	20	5	25 (36.2)
4. Haryana . .	118	76	40	116 (98.3)	42	20	62 (52.5)	28	10	38 (32.2)
5. Himachal Pradesh . .	97	47	23	70 (72.2)	21	11	32 (33.0)	31	17	48 (49.5)
6. Jammu & Kashmir . .	79	44	34	78 (98.7)	3	4	7 (8.9)	12	12	24 (30.4)
7. Karnataka . .	88	34	16	50 (56.8)	47	23	70 (79.5)	9	3	12 (13.6)
8. Kerala . .	104	59	33	92 (88.5)	64	35	99 (95.2)	59	35	94 (90.4)
9. Madhya Pradesh . .	94	51	37	88 (93.6)	21	14	35 (37.2)	26	10	36 (38.3)
10. Maharashtra . .	71	17	11	28 (39.4)	15	3	18 (25.4)	19	9	28 (39.4)
11. Orissa . .	41	9	8	17 (41.5)	19	16	35 (85.4)	1	2	3 (7.3)
12. Punjab . .	66	37	19	56 (84.8)	4	—	4 (6.1)	13	3	16 (24.2)
13. Rajasthan . .	111	66	36	102 (91.9)	50	30	80 (72.1)	32	10	42 (37.8)
14. Tamil Nadu . .	80	27	16	43 (53.8)	37	25	62 (77.5)	13	6	19 (23.8)
15. Uttar Pradesh . .	113	64	33	97 (85.8)	12	5	17 (15.0)	32	15	47 (41.6)
16. West Bengal . .	116	72	38	110 (94.8)	24	11	35 (30.2)	8	4	12 (10.3)
<b>Total . .</b>	<b>1440</b>	<b>749</b>	<b>428</b>	<b>1177 (81.7)</b>	<b>417</b>	<b>221</b>	<b>638 (44.3)</b>	<b>339</b>	<b>153</b>	<b>492 (34.2)</b>

(Appendix Table — 4.5 contd.)

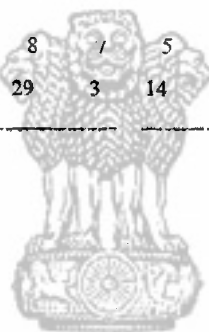
State	No. of Respondents reporting contact	No. of Respondents reporting contact with Mass Media								
		Hoardings/Posters			Pamphlets/Folders			Television		
		Adop- ters	Non- Adop- ters	Total	Adop- ters	Non- Adop- ters	Total	Adop- ters	Non- Adop- ters	Total
1	2	12	13	14	15	16	17	18	19	20
1 Andhra Pradesh	73	9	11	20 (27.4)	1	3	4 (5.5)	..	..	..
2 Bihar	120	38	22	60 (50.0)	15	8	27 (22.5)	2	..	2 (1.7)
3 Gujarat	69	12	11	23 (33.3)	2	1	3 (4.3)	1	..	1 (1.4)
4 Haryana	118	4	1	5 (4.2)	7	4	11 (9.3)	17	9	26 (22.0)
5 Himachal Pradesh	97	19	14	33 (34.0)	7	4	11 (11.3)	..	..	..
6 Jammu & Kashmir	79	1	2	3 (3.8)	1	3	4 (5.1)	6	1	7 (8.9)
7 Karnataka	88	44	27	71 (80.7)	10	2	12 (13.6)	..	..	..
8 Kerala	104	4	1	5 (4.8)	1	1	2 (1.9)	..	..	..
9 Madhya Pradesh	94	30	32	62 (66.0)	5	4	9 (9.6)	1	1	2 (2.1)
10 Maharashtra	71	9	9	18 (25.4)	6	2	8 (11.3)	..	..	..
11 Orissa	41	5	5	10 (24.4)	..	2	2 (4.9)	..	..	..
12 Punjab	66	17	8	25 (37.9)	..	..	..	7	2	9 (13.6)
13 Rajasthan	111	20	13	33 (29.7)	4	..	4 (3.6)	2	..	2 (1.8)
14 Tamil Nadu	80	..	1	1 (1.3)	..	1	1 (1.3)	..	..	..
15 Uttar Pradesh	113	19	8	27 (23.9)	5	2	7 (6.2)	..	..	..
16 West Bengal	116	59	36	95 (81.9)	19	11	30 (25.9)	..	..	..
TOTAL	1440	290	201	491 (34.1)	87	48	135 (9.4)	36	13	49 (3.4)

Percentages in parentheses of cols. 5, 8, 11, 14, 17 and 20 to col. 2.

Appendix Table — 4.6

Annual Frequency of Visit of Family Planning/PHC Staff to the Selected Villages.

Category of Staff	No. of villages reporting frequency of visits (out of 124 villages)																
	1980-81									1981-82							
	Frequency of visits									Frequency of visits							
	Nil	1—12	13 to 24	25 to 52	53 and above	Can-not say	Not reporting due to			Nil	1—12	13 to 24	25 to 52	53 and above	Can-not say	Not reporting due to	
							Hqrs. Post vill- age	vac- ant								Hqrs. Post vill- age	vac- ant
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	
1 Medical Officer . . . . .	27	65	14	5	5	1	5	2	24	61	18	8	5	1	7	..	
2 Lady Health Visitor . . . . .	24	57	12	13	5	—	2	11	24	52	18	12	5	1	2	10	
3 Block Extension Educator . . . . .	21	64	13	9	2	3	2	10	24	58	19	9	1	3	2	8	
4 Health Assistant/ FWHA . . . . .	21	37	17	7	8	7	5	22	21	30	22	8	9	8	5	21	
5 ANM . . . . .	11	19	17	23	29	3	14	8	11	17	21	25	29	4	13	4	



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(Appendix Table — 4.6 contd.)

Category of Staff	No. of villages reporting frequency of visits (out of 124 villages)								
	1982-83								
	Frequency of visits								
	Nil	1—12	13 to 24	25 to 52	53 and abo- ve	Can- not say	Not repor- ting due to		
							Hqrs. vill- age	Post vac- ant	
1	18	19	20	21	22	23	24	25	
1 Medical Officer .	27	66	14	5	5	..	7	..	
2 Lady Health Visitor .	22	64	13	10	3	..	2	10	
3 Block Extension Educator . . .	25	73	10	4	2	..	2	8	
4 Health Assistant/ FWHA . . .	19	35	21	7	9	7	5	21	
5 ANM . . .	7	27	18	24	30	2	13	3	

N.B. Frequency of visit is in terms of number of days in a year a village was visited.



Appendix Table — 4.7

*Statewise Frequency of Visit to the Selected Villages During 1981-82 by*(a) *Medical Officers*

Sl. No.	State	No. of selected villages	Medical Officer						No. of villages reporting	
			Nil	1—12	13—24	25—52	53 and above	Cannot say	Hqrs. village	Post vacant
1	2	3	4	5	6	7	8	9	10	11
1	Andhra Pradesh	8	..	7	1	..	..	..	..	..
2	Bihar	8	..	3	2	3	..	..	..	..
3	Gujarat	8	..	7	1	..	..	..	..	..
4	Haryana	8	..	2	3	3	..	..	..	..
5	Himachal Pradesh	8	3	5	..	..	..	..	..	..
6	Jammu & Kashmir	8	..	..	1	..	4	..	3	..
7	Karnataka	8	..	6	1	1	..	..	..	..
8	Kerala	8	..	2	3	1	..	..	2	..
9	Madhya Pradesh	8	4	..	2	..	1	1	..	..
10	Maharashtra	8	..	6	2	..	..	..	..	..
11	Orissa	4	..	4	..	..	..	..	..	..
12	Punjab	8	3	3	..	..	..	..	2	..
13	Rajasthan	8	2	6	..	..	..	..	..	..
14	Tamil Nadu	8	2	4	2	..	..	..	..	..
15	Uttar Pradesh	8	2	6	..	..	..	..	..	..
16	West Bengal	8	8	..	..	..	..	..	..	..
TOTAL		124	24	61	18	8	5	1	7	..

(Appendix Table 4.7 Contd.)

(b) Lady Health Visitors

Sl. No.	State	No. of selected villages	Nil	1—12	13—24	25—52	53 and above	Cannot say	No. of villagers reporting	
									Hqrs. village	Post vacant
1	2	3	4	5	6	7	8	9	10	11
1	Andhra Pradesh	8	—	6	—	2	—	—	—	—
2	Bihar	8	—	2	1	2	1	—	—	2
3	Gujarat	8	1	5	2	—	—	—	—	—
4	Haryana	8	2	4	1	1	—	—	—	—
5	Himachal Pradesh	8	2	6	—	—	—	—	—	—
6	Jammu & Kashmir	8	1	3	1	1	2	—	—	—
7	Karnataka	8	—	4	4	—	—	—	—	—
8	Kerala	8	1	—	4	—	1	—	2	—
9	Madhya Pradesh	8	1	4	1	1	—	1	—	—
10	Maharashtra	8	—	4	—	—	—	—	—	4
11	Orissa	4	—	2	1	1	—	—	—	—
12	Punjab	8	1	2	1	2	—	—	—	2
13	Rajasthan	8	5	1	—	—	—	—	—	2
14	Tamil Nadu	8	—	4	1	2	1	—	—	—
15	Uttar Pradesh	8	4	3	1	—	—	—	—	—
16	West Bengal	8	6	2	—	—	—	—	—	—
TOTAL		124	24	52	18	12	5	1	2	10

**Appendix Table—4.8**

*Role assigned to Voluntary Agencies, etc. in the Implementation of Family Planning Programmes in the Selected Countries*



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Appendix Table—4·9

*Role Played by Voluntary Agencies etc., in the Implementation of Family Planning Programme in Selected Villages*

Role played	No. of villages reporting role played by				
	Village and local leaders	School teachers	Panchayat	Mahila mandals/ Yuvak mandals	Other voluntary Organisations
1	2	3	4	5	6
1. Motivational work . . . . .	74 (73·7)	55 (53·8)	51 (55·4)	16 (55·2)	5 (25·0)
2. Assistance in organising Mass Campaign/Meetings . . . . .	37 (39·4)	26 (32·5)	36 (39·1)	13 (44·8)	7 (35·0)
3. Helping in Extension/Health Education . . . . .	21 (22·3)	17 (21·2)	22 (23·9)	7 (24·1)	6 (30·0)
4. Helping in availing Medical Assistance/Treatment . . . . .	4 (4·3)	4 (5·0)	5 (5·4)	2 (6·9)	2 (10·0)
5. Assistance in survey of eligible couples and maintenance of records . . . . .	4 (4·3)	4 (5·0)	4 (4·3)	2 (6·9)	—
6. Helping in arranging camps . . . . .	6 (6·4)	3 (3·8)	9 (9·9)	2 (6·9)	5 (25·0)
7. Arranging M.C.H. services . . . . .	1 (1·1)	—	—	—	3 (15·0)
8. To assist depot holders . . . . .	2 (2·1)	7 (8·8)	—	1 (3·4)	—
9. To guide people to avail financial assistance . . . . .	—	—	8 (8·7)	—	—
10. No. of villages reporting role played . . . . .	94 (75·8)	80 (64·5)	92 (74·2)	29 (23·4)	20 (16·1)
11. No. of villages reporting no role played . . . . .	30 (24·2)	14 (35·5)	24 (19·4)	4 (3·2)	5 (4·0)
12. No. of villages having no such agency . . . . .	—	—	8 (6·4)	91 (73·4)	99 (79·9)
Total No. of selected villages . . . . .	124	124	124	124	124

N.B:— Figures in brackets are percentages.



Appendix Table—5.1

State and District-wise Distribution of Non-Adopters According to Awareness About Family Planning Programme

State	District (Progressive/Non-progressive)	No. of non adopters	No. of non-adopters reporting Awareness
1	2	3	4
1. Andhra Pradesh	1. West Godavari (P) 2. Medak (NP)	18 20	18 20
2. Bihar	3. Patna (P) 4. West Champaran (NP)	20 20	20 20
3. Gujarat	5. Kheda (P) 6. Kutch (NP)	20 18	19 14
4. Haryana	7. Rohtak (P) 8. Ambala (NP)	20 20	20 20
5. Himachal Pradesh	9. Hamirpur (P) 10. Sirmur (NP)	20 19	20 18
6. Jammu & Kashmir	11. Srinagar/Budgam (P) 12. Kathua (NP)	20 20	20 20
7. Karnataka	13. Mandya (P) 14. Gulbarga (NP)	18 20	18 20
8. Kerala	15. Trivandrum (P) 16. Palghat (NP)	19 19	19 19
9. Madhya Pradesh	17. Indore (P) 18. Rewa (NP)	20 20	20 20
10. Maharashtra	19. Amravati (P) 20. Parbhani (NP)	20 16	20 14
11. Orissa	21. Phulbani (NP)	20	20
12. Punjab	22. Ropar (P) 23. Faridkot (NP)	19 20	19 20
13. Rajasthan	24. Sriganga Nagar (P) 25. Barmer (NP)	20 20	20 20
14. Tamil Nadu	26. Madurai (P) 27. Ramnad (NP)	20 20	14 20
15. Uttar Pradesh	28. Nainital (P) 29. Lakhimpur Kheri (NP)	20 20	20 19
16. West Bengal	30. Nadia (P) 31. Howrah (NP)	20 20	20 20
Total	Progressive (15) Districts—(P)	294	287 (97.6)
	Non-Progressive (16) Districts—NP	312	304 (97.4)
	All Districts (31)	606	591 (97.5)

P—Progressive districts  
NP—Non-progressive districts

Appendix Table—5.2

*Distribution of Non-adopters by the Category of Staff, etc., Who Made Subsequent Contacts with Them*

Category of staff, etc.	Progressive districts	Non-progressive districts	All districts
1	2	3	4
1. Auxilary Nurse/Mid-wife . . . . .	90(37.5)	77(39.1)	167(38.1)
2. Other family planning staff . . . . .	73(30.4)	62(31.5)	135(30.9)
3. Motivators . . . . .	57(23.8)	36(18.3)	93(21.3)
4. Village Health Guide . . . . .	69(28.8)	23(11.7)	92(21.2)
5. Lady Health Visitor (LHV)/Public Health Nurse (PHN) . . . . .	22(9.2)	58(29.4)	80(18.3)
6. Adopters of Family Planning Methods . . . . .	41(17.1)	27(13.7)	68(15.6)
7. Extension Educator . . . . .	37(15.4)	12(6.1)	49(11.2)
8. Friends . . . . .	27(11.3)	15(7.6)	42(9.6)
9. Doctors . . . . .	25(10.4)	14(7.1)	39(8.9)
10. Relatives . . . . .	11(4.6)	12(6.1)	23(5.3)
11. Community Leaders . . . . .	15(6.3)	5(2.5)	20(4.6)
12. Block staff . . . . .	8(3.3)	6(3.0)	14(3.2)
13. Through Mass Media/Literature . . . . .	5(2.1)	9(4.6)	14(3.2)
14. Spouse . . . . .	0(0.0)	2(1.0)	2(1.5)
15. Voluntary Agencies . . . . .	0(0.0)	1(0.5)	1(0.2)
16. Others . . . . .	6(2.5)	19(9.6)	25(5.6)
Total Non-adopters . . . . .	240(100.0)	197(100.0)	437(100.0)

N.B.:— 1. Figures in brackets are percentages.  
2. Respondents gave multiple responses.

Appendix Table-5.3

*Distribution of Sample Adopters and Non-adopters by the Knowledge of Different Methods of Family Planning*

Family Planning Methods	Adopters			Non-adopters		
	Progressive districts	Non-progressive districts	All districts	Progressive districts	Non-progressive districts	All districts
1	2	3	4	5	6	7
1. Tubectomy . . . . .	405(77.4)	415(82.8)	820(80.1)	181(63.1)	219(72.0)	400(67.7)
2. Vasectomy . . . . .	267(51.1)	266(53.1)	533(52.1)	169(58.9)	144(47.4)	313(53.0)
3. IUD/Copper-T . . . . .	234(44.7)	224(44.7)	458(44.7)	57(19.9)	108(35.5)	165(27.9)
4. Condom . . . . .	217(41.5)	196(39.1)	413(40.3)	86(30.0)	50(16.4)	136(23.0)
5. Oral pills . . . . .	74(14.2)	59(11.8)	133(13.0)	15(5.2)	3(1.0)	18(3.0)
6. Rhythm method . . . . .	7(1.3)	5(1.0)	12(1.2)	1(0.3)	0(0.0)	1(0.2)
7. Foam tablets . . . . .	1(0.2)	3(0.6)	4(0.4)	6(2.1)	5(1.6)	11(1.9)
8. M.T.P. . . . .	1(0.2)	3(0.6)	4(0.4)	0(0.0)	1(0.3)	1(0.2)
9. Abstinence . . . . .	0(0.0)	4(0.8)	4(0.4)	1(0.3)	1(0.3)	2(0.3)
10. Withdrawal . . . . .	0(0.0)	3(0.6)	3(0.3)	0(0.0)	0(0.0)	0(0.0)
11. Condom & Jelly . . . . .	0(0.0)	2(0.4)	2(0.2)	0(0.0)	0(0.0)	0(0.0)
12. Cream & diaphragm . . . . .	0(0.0)	1(0.2)	1(0.1)	0(0.0)	0(0.0)	0(0.0)
13. Others . . . . .	0(0.0)	1(0.2)	1(0.1)	3(1.0)	12(3.9)	15(2.5)
Total No. of respondents						
Males . . . . .	195	165	360	NA	NA	NA
Females . . . . .	328	336	664	NA	NA	NA
Total . . . . .	523	501	1024	287	304	591

N.B.:—Figures in brackets are percentages.

**Appendix Table—5.4**  
*Views of Sample Adopters and Non-adopters on Benefits  
 Expected from the Adoption of Family Planning*

Benefits expected	Adopters			Non-adopters		
	Progressive districts	Non-Progressive districts	All districts	Progressive districts	Non-Progressive districts	All districts
1	2	3	4	5	6	7
1. Small & happy family . . . . .	337(64.4)	298(59.5)	635(62.0)	126(43.9)	143(47.0)	269(45.5)
2. Will help in better care of children . . . . .	282(53.9)	244(48.7)	526(51.4)	108(37.6)	106(34.9)	214(36.2)
3. Large family difficult to provide for . . . . .	237(45.3)	262(52.3)	499(48.7)	123(42.9)	156(51.3)	279(47.2)
4. In the interest of wife's health . . . . .	100(19.1)	77(15.4)	177(17.3)	47(16.4)	27(8.9)	74(12.5)
5. Will help spacing children . . . . .	41(7.8)	67(13.4)	108(19.6)	7(2.4)	10(3.3)	17(2.9)
6. Will help maintain/improve living standards . . . . .	46(8.8)	60(12.0)	106(10.4)	20(7.0)	42(13.8)	62(10.5)
7. Easy to adopt . . . . .	64(12.2)	32(6.4)	96(9.4)	35(12.2)	23(7.6)	58(9.8)
8. Small family is in national interest . . . . .	51(9.8)	39(7.8)	90(8.8)	10(3.5)	31(10.2)	41(6.9)
9. Will help avoid division and fragmentation of property . . . . .	41(7.8)	42(8.4)	83(8.1)	16(5.6)	9(3.0)	25(4.2)
10. Incentives available under the scheme . . . . .	39(7.5)	14(2.8)	53(5.2)	27(9.4)	7(2.3)	34(5.8)
11. It is reversible . . . . .	9(1.7)	1(0.2)	10(1.0)	7(2.4)	1(0.3)	8(1.4)
12. Others . . . . .	2(0.4)	7(1.4)	9(0.9)	3(1.0)	0(0.0)	3(0.5)
<b>Total . . . . .</b>	<b>523</b>	<b>501</b>	<b>1024</b>	<b>287</b>	<b>304</b>	<b>591</b>

N.B. :—1. Figures in brackets are percentages.  
 2. Respondents gave multiple replies.

**Appendix Table—5.5**  
**Views of Sample Non-adopters to the Message of Benefits**  
**Expected from the Adoption of Family Planning**

Benefits of Family Planning Programme	No. reporting (N=591)	Percentage of Non-adopters reporting		
		Favourable	Un-favourable	No reaction
1	2	3	4	5
1. Large family difficult to afford (Economic reason)	279 (47.2)	60.6	21.1	18.3
2. Small Family, happy family	269 (45.5)	68.8	13.0	18.2
3. Will help better care of children (health and education)	214 (36.2)	64.0	22.0	14.0
4. In the interest of wife's health	74 (12.5)	60.8	20.3	18.9
5. Will help to maintain/improve standard	62 (10.2)	58.1	22.6	19.3
6. Family Planning Methods easy to adopt	58 (9.8)	65.5	17.2	17.2
7. Small Family in national interest (to limit population)	41 (6.9)	51.2	29.3	19.5
8. Incentives provided (cash, kind & other facilities)	34 (5.8)	61.8	23.5	14.7
9. Will avoid further division of property	25 (4.2)	40.0	28.0	32.0
10. Will help in spacing of children	17 (2.9)	88.2	5.9	5.9
11. Reversible	8 (1.4)	87.5	0.0	12.5
12. Others	3 (0.5)	100.0	0.0	0.0

N.B. :—1. Percentages in Col. 2 to total number reporting (591).

2. Percentages in Cols. 3—5 to Col. 2.

Appendix Table-5.6

*Views of Non-adopters on Different Family Planning Methods*

Family Planning Methods	No. reporting (N=591)	Percentage of non-adopters reporting reaction		
		Favourable	Un-favourable	No reaction
1	2	3	4	5
1. Tubectomy . . . . .	400 (67.7)	46.0	32.3	21.7
2. Vasectomy . . . . .	313 (53.0)	35.5	49.5	15.0
3. IUD/Coper-T . . . . .	165 (27.9)	49.1	29.7	21.2
4. Condom . . . . .	136 (23.0)	36.8	37.5	25.7
5. Oral Pills . . . . .	18 (3.0)	50.0	22.2	27.8
6. Foam Tablets . . . . .	11 (1.9)	36.4	36.4	27.3
7. Abstinence . . . . .	2 (0.3)	0.0	50.0	50.0
8. Jelly/Cream Tubes . . . . .	1 (0.2)	0.0	0.0	100.0
9. Medical Termination of Pregnancy (MTP) . . . . .	1 (0.2)	0.0	0.0	100.0
10. Rhythm (Safe period) . . . . .	1 (0.2)	0.0	0.0	100.0
11. Others . . . . .	15 (2.5)	40.0	20.0	40.0

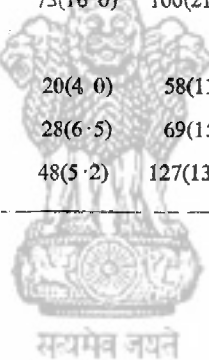
N.B. :—1. Percentage in Col. 2 to total No. reporting (591).  
 2. Percentage in Cols. 3—5 to Col. 2.

Appendix Table—6·1

*Distribution of Sample Adopters by Time-lag Involved Between the Stages of Awareness, Acceptance and Adoption of the Family Planning Programme*

Stages involved	Time-lag involved (months)						Total No. of adopters reporting
	Less than 6	6 to less than 12	12 to less than 24	24 to less than 48	48 to less than 96	96 and more	
1	2	3	4	5	6	7	8
<b>1. Awareness and Acceptance</b>							
(i) Progressive districts . . . . .	17(3·9)	17(3·9)	67(15·3)	156(35·6)	164(37·4)	17(3·9)	438(100·0)
(ii) Non-progressive districts . . . . .	25(7·3)	23(6·7)	52(15·2)	105(30·6)	123(35·9)	15(4·4)	343(100·0)
(iii) All districts . . . . .	42(5·4)	40(5·1)	119(15·2)	261(33·4)	287(36·7)	32(4·1)	781(100·0)
<b>2. Acceptance and Adoption</b>							
(i) Progressive districts . . . . .	73(26·2)	47(16·8)	58(20·8)	42(15·1)	53(19·0)	6(2·2)	279(100·0)
(ii) Non-progressive districts . . . . .	34(19·1)	26(14·6)	42(23·6)	50(28·1)	23(12·9)	3(1·7)	178(100·0)
(iii) All districts . . . . .	107(23·4)	73(16·0)	100(21·9)	92(20·1)	76(16·6)	9(2·0)	457(100·0)
<b>3. Awareness &amp; Adoption</b>							
(i) Progressive districts . . . . .	20(4·0)	20(4·0)	58(11·7)	141(28·4)	209(42·1)	48(9·7)	496(100·0)
(ii) Non-progressive districts . . . . .	34(7·8)	28(6·5)	69(15·9)	124(28·6)	160(36·9)	19(4·4)	434(100·0)
(iii) All districts . . . . .	54(5·8)	48(5·2)	127(13·7)	265(28·5)	369(39·7)	67(7·2)	930(100·0)

N.B. : Figures in brackets are percentages



Appendix Table - 6.2

Distribution of Sample Adopters by Reasons for Time-lag Between Awareness and Acceptance and Between Acceptance and Adoption

Reasons for time lag	Reasons for time lag -between					
	Awareness and Acceptance (No. of adopters)			Acceptance and Adoption (No. of adopters)		
	Progressive districts	Non- progressive districts	All districts	Progressive districts	non- progressive districts	All districts
1	2	3	4	5	6	7
<i>Fears &amp; misconceptions</i>						
(i) Fears of after effects . . . . .	86(19.6)	70(20.4)	156(20.0)	55(19.7)	30(16.9)	85(19.0)
(ii) Not fully convinced . . . . .	82(18.7)	69(20.1)	151(19.3)	5(1.8)	13(7.3)	18(3.9)
(iii) Fears of undergoing operation . . . . .	64(14.6)	53(15.5)	117(15.2)	44(15.8)	15(8.4)	59(12.9)
	(52.9)	(56.0)	(54.5)	(37.3)	(32.6)	(35.8)
<i>Desire for more children</i>						
(i) More children . . . . .	133(30.4)	88(25.7)	221(28.5)	41(14.7)	26(14.6)	67(14.7)
(ii) Male child . . . . .	50(11.4)	36(10.5)	86(11.0)	31(11.1)	15(8.4)	46(10.1)
(iii) Female child . . . . .	13(3.0)	10(2.9)	23(2.9)	4(1.4)	12(6.7)	16(3.5)
	(44.8)	(39.1)	(42.4)	(27.2)	(29.7)	(28.3)
<i>Objection by spouse and discouragement by friends and relatives.</i>						
(i) Objection from spouse . . . . .	62(14.2)	64(18.7)	126(16.1)	47(16.8)	28(15.7)	75(16.4)
(ii) Discouragement by friends & relatives . . . . .	38(8.6)	38(11.1)	76(9.7)	35(12.5)	23(12.9)	58(12.7)
	(22.8)	(29.8)	(25.8)	(29.3)	(28.6)	(29.1)
Medical & Health grounds <sup>1</sup> . . . . .	74(16.9)	62(18.2)	136(17.4)	83(29.7)	47(26.4)	130(28.4)
Pre-occupation with work . . . . .	30(6.8)	36(10.5)	66(8.5)	30(10.8)	22(12.4)	52(11.4)
Cultural & religious <sup>2</sup> . . . . .	12(2.7)	7(2.0)	19(2.4)	8(2.9)	2(1.1)	10(2.2)
Difficulties in getting contraceptives/family planning services . . . . .	4(0.9)	9(2.6)	13(1.7)	4(1.4)	4(2.2)	8(1.8)
Total number of adopters reporting time-lag	438	343	781	279	178	457

N.B.:—1. Figures in brackets are percentages

2. Since a number of respondents gave more than one reply the percentages add up to more than 100.



Appendix Table -6.3

Distribution of Non-adopters by Reasons for Non-adoption of Family Planning Methods

Reasons	Non-adopters (No.=606)
<b>1. Fears and Misconceptions</b>	
(i) Harmful to health . . . . .	118(19.5)
(ii) No faith . . . . .	80(13.2)
(iii) Would lead to sterility . . . . .	57(9.4)
(iv) Apprehension . . . . .	42(6.9)
(v) Risky . . . . .	23(3.8)
(vi) Not reliable . . . . .	18(3.0)
(vii) Affect mental health . . . . .	17(2.8)
(viii) No confidence in family planning staff . . . . .	9(1.5)
(ix) Leads to impotency . . . . .	11(1.8)
Sub-Total	375(61.1)
<b>2. More Children</b>	
(i) Male child . . . . .	167(27.6)
(ii) More children . . . . .	69(11.4)
(iii) Female child . . . . .	32(5.3)
Sub-Total	268(44.3)
<b>3. Objection by spouse and discouragement by relatives &amp; Friends</b>	
(i) Objection by spouse . . . . .	74(12.2)
(ii) Discouragement by relatives & Friends . . . . .	16(2.6)
Sub-Total	90(14.8)
<b>4. Cultural &amp; Religious</b>	
(i) Cultural and Religious . . . . .	37(6.1)
(ii) Immoral/sinful . . . . .	17(2.8)
Sub-Total	54(8.9)
<b>5. Others</b>	
(i) Not satisfied with arrangement . . . . .	34(5.6)
(ii) Not satisfied with incentives . . . . .	29(4.8)
(iii) Indifferent to family size . . . . .	27(4.5)
(iv) No knowledge of family planning methods . . . . .	17(2.8)
(v) No privacy . . . . .	9(1.5)
(vi) Others . . . . .	72(11.9)
Sub-Total	188(31.1)

N.B.:— 1. Figures in brackets are percentages.

2. Respondents gave multiple replies. Percentages therefore add up to more than 100.

3. Reasons reported by less than one per cent of total non-adopters have been omitted.

Appendix Table — 6.4

Distribution of adopters According to Reasons for Adopting Family Planning

Reasons for adopting family planning programme	Progressive districts (N=523)	Non-progressive districts (N=501)	All districts (N=1024)
1	2	3	4
<b>1. Economic Reasons</b>			
(i) Large family difficult to afford . . . . .	142(27.2)	133(26.5)	275(26.9)
(ii) Helps to maintain/improve living standard . . . . .	18(3.4)	14(2.8)	32(3.1)
(iii) Helps to avoid further division of property . . . . .	7(1.3)	8(1.6)	15(1.5)
(iv) Incentive given . . . . .	4(0.8)	6(1.2)	10(1.0)
(v) Helps to take better care of children's health and education . . . . .	81(15.5)	95(19.0)	176(17.2)
Sub-total . . . . .	252(48.2)	256(51.1)	508(49.6)
<b>2. Medical and Health Grounds</b>			
(i) In the interest of wife's health . . . . .	34(6.5)	49(9.8)	83(8.1)
(ii) Helps in spacing children . . . . .	50(9.6)	45(9.0)	95(9.3)
Sub-total . . . . .	84(16.1)	94(18.8)	178(17.4)
<b>3. Family Planning Methods</b>			
(i) Methods easy to adopt . . . . .	18(3.4)	11(2.2)	29(2.8)
(ii) Methods reversible, if desired . . . . .	11(2.1)	1(0.2)	12(1.2)
Sub-total . . . . .	29(5.5)	12(2.4)	41(4.0)
<b>4. General Reasons</b>			
(i) Small family, happy family . . . . .	115(22.0)	113(22.6)	228(22.3)
(ii) Small family in national interest . . . . .	30(5.7)	23(4.6)	53(5.2)
(iii) Others . . . . .	13(2.5)	3(0.6)	16(1.6)
Sub-total . . . . .	158(30.2)	139(27.8)	297(29.1)

N.B. Figures in brackets are percentages.

Appendix Table--6.5

*Distribution of Sample Adopters by Suggestions Offered by Them for Improvement Regarding Specific Aspects of the Family Planning Programme*

Item	Aspects on which suggestions offered						
	Avail-ability of family planning staff at village level	Frequency of contact/visit of family planning officials with villagers	Timely avail-ability of supplies/ services	Quality of family planning devices/ medicines	Quality of family planning devices/ services	Follow-up family planning staff after adoption	Other aspects
1	2	3	4	5	6	7	8
1. No. of sample adopters offering suggestions . . . . .	451	461	385	271	314	534	61
2. No. offering :							
(i) One suggestion . . . . .	382(84.7)	410( 88.9)	351(91.2)	268(98.9)	306(97.5)	497(93.1)	61(100.0)
(ii) Two suggestions . . . . .	69(15.3)	51(11.1)	34(8.2)	3(1.1)	8(2.5)	37(6.9)	0(0.0)
(iii) Total no. of suggestions offered (i)+(ii) . . . . .	520	512	419	274	322	571	61
3. Suggestions offered :							
(i) Area of jurisdiction to be reduced/more staff should be posted . . . . .	359(79.6)	28(6.1)	8(2.1)	..	..	..	..
(ii) Facilities of accommodation/transport to be given to staff . . . . .	63(14.0)	57(12.4)	..	..	..	..	..
(iii) Incentives to staff to be increased . . . . .	10(2.2)	9(2.0)	..	..	..	..	..
(iv) More frequent domiciliary visits by family planning staff . . . . .	44(9.8)	365(79.2)	11(2.9)	..	..	6(1.1)	..
(v) Involvement of panchayats/ local bodies/voluntary organisations/local leaders . . . . .	5(1.1)	..	..	..	..	..	..
(vi) More publicity of the programme to be arranged . . . . .	—	13(2.8)	—	—	—	—	—
(vii) More audio-visual aids to be provided to the field staff . . . . .	—	10(2.2)	—	—	—	—	—
(viii) Regular & adequate supplies of contraceptives/medicines to be ensured . . . . .	—	—	224(58.2)	—	257(81.8)	—	—
(ix) Prompt treatment in the case of complaint . . . . .	—	—	104(27.0)	—	—	69(12.9)	—
(x) More distribution outlets . . . . .	—	—	37(9.6)	—	48(15.3)	—	—
(xi) Better quality of supplies to be ensured . . . . .	—	—	8(2.1)	267(98.5)	—	—	—
(xii) Better follow-up of cases . . . . .	—	—	—	—	—	477(89.3)	—
(xiii) Others . . . . .	39(8.6)	30(6.4)	27(7.1)	7(2.6)	17(5.4)	19(3.6)	61(100.0)
Total	520 (100.0)	512 (100.0)	419 (100.0)	274 (100.0)	322 (100.0)	571(100.0)	61(100.0)

N.B. :—Figures in brackets are percentages.

Appendix Table—7.1

*Distribution of Sample Adopters by Methods Practised and Reasons for Preference*

Reasons for Preference	Vasectomy	Tubectomy	IUD/ Copper-T	Condom	Oral Pill
1	2	3	4	5	6
1. Better & more reliable method to prevent pregnancy	46(45.1)	234(48.5)	24(16.2)	14(5.4)	5(15.2)
2. Comfortable and convenience of use					
(i) No more botheration	57(55.9)	160(33.1)	13(8.8)	16(6.2)	2 ( 6.1)
(ii) Easy to adopt and no discomfort	14(13.7)	74(15.3)	41(27.7)	165(64.0)	23(69.7)
(iii) Able to keep privacy	0(0.0)	1(0.2)	14(9.5)	35(13.6)	4(12.1)
Total 2	71(69.6)	235(48.6)	68 (46.0)	216(83.8)	29(87.9)
3. Advised by:—					
(i) Spouse, relatives and friends	6(5.9)	83(17.2)	13 ( 8.8)	8 ( 3.1)	4(12.1)
(ii) Health Staff and others*	24(23.5)	156(29.7)	32(21.6)	28(10.6)	2(6.0)
Total 3	30(29.4)	239(46.9)	45(30.4)	36(13.7)	6(18.1)
4. Good for spacing/reversible	2(2.0)†	1(0.2)†	83(56.1)	122(49.3)	16(48.5)
5. Money incentive	7(6.8)	28(5.8)	0(0.0)	0(0.0)	0(0.0)
6. No. after effects	0(0.0)	49(10.1)	8(5.4)	37(14.3)	1(3.0)
Total (4+5+6)	9(8.8)	78(16.1)	91(61.5)	159(61.6)	17(51.5)
Total No. of adopters	102	483	148	258	33

N.B:— 1. Figures in brackets are percentages.

2. Respondents gave multiple replies. The percentages therefore add up to more than 100.

\* Includes advice by motivators as well as medical advice.

† The respondents apparently believed these to be so.

Appendix Table- 7.2

*Distribution of Dissatisfied Sample Adopters by Reasons for Dissatisfaction*

Reasons for Dissatisfaction	Vasectomy	Tubectomy	IDU/ Copper-T	Condom	Oral Pills	Total
1	2	3	4	5	6	7
1. Physical Discomfort to:—						
(i) Self	10 (76.9)	41 (56.9)	7 (33.3)	3 (6.1)	2 (33.3)	63 (39.1)
(ii) Wife	0 (0.0)	0 (0.0)	0 (0.0)	7 (14.3)	0 (0.0)	7 (4.4)
Sub-Total	10 (76.9)	41 (56.9)	7 (33.3)	10 (20.4)	2 (33.3)	70 (43.5)
2. Not Safe/Harmful						
(i) Not very safe	0 (0.0)	1 (1.4)	1 (4.8)	25 (51.0)	0 (0.0)	27 (16.8)
(ii) Failure of method	0 (0.0)	3 (4.2)	0 (0.0)	7 (14.3)	0 (0.0)	10 (6.2)
(iii) Harmful to health	2 (15.4)	21 (29.2)	6 (28.6)	5 (10.2)	1 (16.7)	35 (21.7)
(iv) Bad after effects	6 (46.2)	37 (51.4)	5 (23.8)	2 (4.1)	2 (33.3)	52 (32.3)
Sub-Total	8 (61.6)	62 (86.2)	12 (57.1)	39 (79.6)	3 (50.0)	124 (77.0)
3. Satisfaction/Pleasure decreases	1 (7.7)	1 (1.4)	0 (0.0)	18 (36.7)	0 (0.0)	20 (12.4)
4. Difficult in practising	0 (0.0)	0 (0.0)	0 (0.0)	8 (16.3)	0 (0.0)	8 (5.0)
5. Others	4 (30.8)	22 (30.6)	9 (42.9)	9 (18.4)	3 (50.0)	47 (29.2)
Sub—Total	5 (38.5)	23 (31.9)	9 (42.9)	35 (71.4)	3 (50.0)	75 (46.6)
Total No. of dissatisfied adopters	13	72	21	49	6	161

N.B:— 1. Figures in brackets are percentages.

2. Respondents gave more than one reason for dissatisfaction.